

9718

CERTIFICATE OF DEATH

Reg. Dist. No. 09728
131

1. PLACE OF DEATH:

COUNTY Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL or and give nearest town)
FrederickLENGTH OF STAY
(in this place)
LifetimeHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Frederick Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY Frederick

CITY (If outside corporate limits, write RURAL and give nearest town)
Araby - Nr. FrederickSTREET ADDRESS
(If rural give location)
Araby3. NAME OF
DECEASED:

(First)

IRA

(Middle)

DANIEL

(Last)

AUSHERMAN

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

October 13 19 55

5. SEX:

Male

6. COLOR OR
RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

Married

8. DATE OF BIRTH:

May 10, 1891

9. AGE last birthday:

64

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of
work done during most of working life,
even if retired.

Section Foreman

10b. KIND OF BUSINESS OR
INDUSTRY:

Railroad

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME:

Lewis Ausherman

14. MOTHER'S MAIDEN NAME:

Ann Catherine DeLauter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

No

16. SOCIAL SECURITY No.:

705-10-2005

17. INFORMANT & ADDRESS:

Mrs. Ira D. Ausherman - Araby, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY
LEADING TO DEATH

420.1

Immediate cause

(a)

DUE TO

Antecedent causes(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between
Onset And Death

10/6/55

10/1/55

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Oct 6, 1955, to Oct 13, 1955, that I last saw the deceased

alive on Oct 13, 1955, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

14 October 1955

Elizabeth G. Heck

C. E. Cline & Son - Frederick, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians write the causes of death clearly and legibly.

UNITED STATES OF AMERICA

8174

BUREAU V. S.

OCT 17 1955

RECEIVED

9719

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN Frederick		LENGTH OF STAY (in this place) 6 Years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 116 East Seventh Street				STREET ADDRESS (If rural give location) 116 East Seventh Street			
3. NAME OF DECEASED: (First) ALMA (Middle) JANE (Last) AXLINE				4. DATE (Month) (Day) (Year) OF DEATH: October 5, 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: 22 July 1888	9. AGE last birthday yrs. 67	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work		10B. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John William Henderson				14. MOTHER'S MAIDEN NAME: Minnie Forrester			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: 116 E. 7th St., Harry D. Axline, Frederick, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carotid Occlusion						15 mi	
ANTECEDENT CAUSE (B) Carotid Sclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Moderate Hypertension						15410	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1953, to 1955, that I last saw the deceased alive on Sept 3, 1955, and that death occurred at 9:45A M, from the causes and on the date stated above.							
SIGNATURE C. J. Jacobson		M. D. Jefferson, Maryland		DATE SIGNED 5 Oct 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8 Oct 1955		NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		LOCATION (City, town, or county) (State) Petersville, Maryland	
DATE REC'D BY LOCAL REGISTRAR 1 Oct 1955		REGISTRAR'S SIGNATURE Elizabeth B. Hesch		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

OCT 10 1955

RECEIVED

9747

CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Frederick</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <i>Woodboro</i>		<i>years</i>		TOWN <i>Woodboro</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>LAURA PRISCILLA BARRICK</i>				<i>Oct 10 19 55</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>AF</i>	<i>W</i>	<i>W</i>	<i>Dec 5, 1870</i>	<i>84</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>housewife</i>		<i>own home</i>		<i>Maryland</i>		<i>USA</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Abraham Long</i>				<i>Amanda Menger</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT'S ADDRESS:	
<i>no</i>				<i>none</i>		<i>Adam Barrick, Woodboro, Md</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Carcinoma left kidney</i>						<i>8 months</i>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<i>urethral stricture</i>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 10, 19 55</i> , to <i>10/10, 19 55</i> , that I last saw the deceased alive on <i>10/10/55</i> , 1955, and that death occurred at <i>8:30 A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>James E. Howard</i>		M. D. <i>Walherville, Md</i>		DATE SIGNED <i>10/10/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Oct 12, 1955</i>		<i>Mt Hope</i>		<i>Woodboro Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>Oct. 12, 1955</i>		<i>J. E. Powell</i>		<i>Powell & Hartley, Woodboro, Md</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 14 1995

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9748

CERTIFICATE OF DEATH

Reg. Dist. No. 09731

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Middletown</u>				OR TOWN <u>Middletown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>LAURA VIRGINIA BEACHLEY</u>				<u>10 - 7 - 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>white</u>	<u>married</u>	<u>2-4-1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>own home</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Lewis Abalt</u>				<u>Margaret Flork</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>none</u>		<u>J. Claude Beachley, Middletown Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>442X Cardio-Renal-Vascular Disease</u>						<u>2 yrs</u>	
ANTECEDENT CAUSE (B) <u>Arterio Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Oct 7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 6</u> , 19 <u>55</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J E Harp</u>		ADDRESS <u>Middletown</u>		DATE SIGNED <u>Oct 7 55</u>		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-10-1955</u>		<u>Lutheran Cemetery</u>		<u>Middletown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-8-1955</u>		<u>Elizabeth S. Hark</u>		<u>Gladhill Co.</u>		<u>Middletown Md.</u>	

BUREAU V. S.

OCT 11 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0973239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Md		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
Rural Sabillasville		40 yrs		Rural Sabillasville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Samuel Phillippy Bittner				Oct 6 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Widowed	Oct. 15. 1883	71 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Own Farm		Penna.		U.S.A	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John C. Bittner				Mary C. Phillippy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		No		Lester G. Bittner Sabillasville Md			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15 Hours			
IMMEDIATE CAUSE				Coronary Thrombosis & Myocardial			
ANTECEDENT CAUSE (S):				Arterio Sclerosis Cardiac Cholesterol			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				4 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6.0.1, 1955 , to 6.0.1, 1955 that I last saw the deceased alive on 6.0.1, 1955 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
SIGNATURE		M. D.		DATE SIGNED			
Robert A. The...		Blue Ridge Summit, Pa.		6.0.1.1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 9. 1955		Blue Ridge Cem.		Thurmont, Fredk. Co. MD	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
10/7/55		[Signature]		M.L. Creager & Son. Thurmont. MD			

RECEIVED
OCT 11 1955
BUREAU V. E.

CERTIFICATE OF DEATH

Reg. Dist. No. 131

09733

9720

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY FREDERICK		MARYLAND		STATE MARYLAND		COUNTY FREDERICK	
CITY (If outside corporate limits, write RURAL OR and give nearest town) FREDERICK		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		OR TOWN Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 914, WALNUT ST.				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) CORA (Middle) M. (Last) BOWERS				4. DATE OF DEATH: (Month) OCT. (Day) 18. (Year) 19 55			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH: Dec. 14, 1872	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: House Wife		10b. KIND OF BUSINESS OR INDUSTRY: House Wife		9. AGE last birthday: 82 yrs. 10 Months 4 Days 4 Hours Min.		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME: Solomon Matthews			
14. MOTHER'S MAIDEN NAME: Isabell Brown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No			
16. SOCIAL SECURITY No.: None				17. INFORMANT & ADDRESS: Roland R. Bowers, Son. 914 Walnut St.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>with Secondary involvement</i>							
Immediate cause (a) Carcinoma of Urinary Bladder of rt Kidney							
Antecedent causes (s) (b) Right Hydronephrosis with long metastasis to pelvis							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug</i> , 1955, to <i>Oct. 18</i> , 1955, that I last saw the deceased alive on <i>Oct 10</i> , 1955, and that death occurred at <i>10:50 PM</i> from the causes and on the date stated above.							
SIGNATURE <i>J. E. Harp MD</i>		(Degree or title)		DATE SIGNED <i>10-19-55</i>		ADDRESS <i>Middle town</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF October 22, '55		NAME OF CEMETERY OR CREMATORY ODD FELLOWS CEMETERY		LOCATION (City, town, or county) (State) MILFORD, DELEWARE	
DATE REC'D BY LOCAL REGISTRAR 20 October 1955		REGISTRAR'S SIGNATURE <i>Elizabeth L. Heck</i>		24. FUNERAL DIRECTOR ROBERT E. DAILEY, 1201, N. Market St.		ADDRESS FREDERICK, Maryland.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JOHN V. E.

9750

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Middletown</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Katie E. Bowlus</i>				<i>10 25 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 1 YEAR	IF UNDER 24 HRS.
<i>Female</i>	<i>white</i>	<i>widowed</i>	<i>2-14-1867</i>	<i>88</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>housewife</i>		<i>own home</i>		<i>Maryland</i>		<i>U. S.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Casper P. Pyper</i>				<i>Clara Muehling</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<i>no</i>		<i>none</i>		<i>G. Aubrey Bowlus, Middletown, Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardio-Renal Vascular disease</i>						<i>3 yrs</i>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <i>Arterio-sclerosis</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1952</i> , 19 <i>to</i> <i>Oct 25, 1955</i> that I last saw the deceased alive on <i>Sept 29 1955</i> , and that death occurred at <i>8 A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>J E Harp</i>		ADDRESS <i>Middletown</i>		DATE SIGNED <i>10-28-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>10-27-1955</i>		<i>Union Cemetery</i>		<i>Burkittsville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>10-26-1955</i>		<i>Elizabeth H. Heck</i>		<i>Gladhill Co., Middletown, Md.</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9751

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH: <u>Shadnock</u> COUNTY <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Knowlton Bridge</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Knowlton Bridge</u> STREET ADDRESS (If rural give location) <u>Rural</u>	
3. NAME OF DECEASED: (Type or Print) <u>IRA CLINTON RUFFINGTON</u> (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 14</u> 19 <u>55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>11/9/1889</u>
9. AGE last birthday: <u>66</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John E. Ruffington</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Ruffington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO.: <u>none</u>	
17. INFORMANT'S ADDRESS: <u>John E. Ruffington, Knowlton Bridge</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
200.1 IMMEDIATE CAUSE (A) <u>Lympho. Sarcoma</u> DUE TO			
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>U</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 2, 1952</u> , to <u>10-14, 1955</u> , that I last saw the deceased alive on <u>10-14, 1955</u> , and that death occurred at <u>2:15</u> M., from the causes and on the date stated above.			
SIGNATURE <u>J. H. Legg</u>		DATE SIGNED <u>MD 10-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>buried</u>		DATE THEREOF <u>10/17/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Union Burial</u>		LOCATION (City, town, or county) (State) <u>Queen Anne's Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Leslie Rapp</u>	
24. FUNERAL DIRECTOR <u>W. L. Rapp</u>		ADDRESS <u>110</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9752

09736
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 141

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Id.</u>		COUNTY <u>F.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Keokuk</u>		<u>2-1</u>		TOWN <u>Keokuk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mountain Road</u>				STREET ADDRESS <u>Mountain Road</u>			
3. NAME OF DECEASED: (First) <u>Edith</u> (Middle) <u>—</u> (Last) <u>Butler</u>				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9-19-1913</u>	9. AGE last birthday: <u>52</u> yrs.	IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even retired): <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>
13. FATHER'S NAME: <u>Henry John</u>				14. MOTHER'S MAIDEN NAME: <u>Miss Mary Ann</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Charles P. Butler, Keokuk, Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p><u>422.1</u></p> <p>Immediate cause (a) <u>Cerebral arteriosclerosis</u> DUE TO</p> <p>Antecedent cause(s) (b) <u>—</u></p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c) <u>—</u></p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Edith Butler</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct 11-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10-15-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Mountain</u>		LOCATION (City, town, or county) (State): <u>Keokuk, Maryland</u>	
DATE REC'D BY LOCAL REG: <u>Oct 12-55</u>		REGISTRAR'S SIGNATURE: <u>Kathryn N. Brown</u>		24. FUNERAL DIRECTOR: <u>C.H. Fulkner</u> ADDRESS: <u>Keokuk, Md</u>			



9721

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		If outside corporate limits, write RURAL and give nearest town)			
<u>Frederick</u>		<u>6 days</u>		<u>Rural, in Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>Hansonville</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>JOHN WALTER CLEMSON</u>				DATE OF DEATH <u>Oct 5 1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>April 19, 1873</u>	
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Nicholas H. Clemson</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Cramer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				17. INFORMANT'S ADDRESS: <u>Balto, Md. Dr. W. Buckley Clemson, 101 Junbridge Rd.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				<u>5 days</u>			
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>9/15/55</u> , 19 <u>55</u> , to <u>10/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/4</u> , 19 <u>55</u> , and that death occurred at <u>3:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James B. Thomas</u>		M. D. <u>Frederick, Md.</u>		DATE SIGNED <u>10/6/55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Glade</u>		LOCATION (City, town, or county) (State) <u>Walkersville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6 Oct 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>		24. FUNERAL DIRECTOR <u>J. E. Barton, Walkersville, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING



9722

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick MARYLAND		STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) OR Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) OR Frederick-Rural RD#6	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural give location) Bartonsville	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) GEORGE WALTER COLLINS		OF DEATH October 4, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Male	Colored	Single	29 Sept 1955
9. AGE last birthday		10. AGE last birthday	
yrs. Months Days		yrs. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
George W. Stanton		Yvonne Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Yvonne Collins, RD#6, Frederick, Md.		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) 760.0 Cerebral anoxia		2 days	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
	OF INJURY	INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 29, 1955, to Oct 4, 1955, that I last saw the deceased alive on Oct 4, 1955, and that death occurred at 5:45 P M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Bernard P. Kuncio		5 Oct 1955	
M. D. Frederick, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5 Oct 1955	Bartonsville Cemetery	Frederick County Maryland
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5 Oct 1955	Elizabeth B. Heck	M. R. Etchison & Son,	Frederick, Maryland

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WILLIAM A. E.

100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9723 CERTIFICATE OF DEATH

Reg. Dist. No.

09739

Item 3:5 in 187 10/12/55

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick		LENGTH OF STAY (in this place) Lifetime		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick		//	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 McMurray Street				STREET ADDRESS (If rural give location) 15 McMurray Street			
3. NAME OF DECEASED: (First) ROBERT (Middle) WAYNE (Last) CRAMER				4. DATE OF DEATH: (Month) October (Day) 9 (Year) 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: September 12, 1955	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:				10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: yrs. 28	
11. BIRTHPLACE (State or foreign country): Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: Robert H. Cramer				14. MOTHER'S MAIDEN NAME: Pauline E. Fox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mr. Robert H. Cramer - Frederick, Maryland	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
754.4 Immediate cause (a) Cardiac failure Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Congenital heart disease (c)						? 28 days	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 10-9-55				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 12, 1955, to Oct. 9, 1955, that I last saw the deceased alive on Sept. 12, 1955, and that death occurred at 10:20 A.M., from the causes and on the date stated above.							
SIGNATURE (Degree or title) Robert S. Zuercher, Jr.				ADDRESS DATE SIGNED 7 E. Church St. Frederick, Md. 10-10-55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Oct. 11, 1955		NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery		LOCATION (City, town, or county) (State) Yellow Springs, Nr. Fre'd., Md.	
DATE REC'D BY LOCAL REGISTRAR 10 October 1955		REGISTRAR'S SIGNATURE Elizabeth B. Hark		24. FUNERAL DIRECTOR C. E. Cline & Son - Frederick, Maryland		ADDRESS	



9753

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cullen		LENGTH OF STAY (in this place) 5565 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital				STREET ADDRESS (If rural give location) 3221 St. Paul Street,			
3. NAME OF DECEASED: (First) (Middle) (Last) Richard W. Davidson				4. DATE (Month) (Day) (Year) OF DEATH: October 20, 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: Jan. 22, 1890	9. AGE last birthday: 65 yrs.	IF UNDER 1 YEAR: Months Days Hours Mln.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel worker		10B. KIND OF BUSINESS OR INDUSTRY: Steel worker		11. BIRTHPLACE (State or foreign country): Dundee, Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Peter Davidson				14. MOTHER'S MAIDEN NAME: Agnes Rollo			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No. 213-09-2388		17. INFORMANT & ADDRESS: ?			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis						15½ years.	
ANTECEDENT CAUSE (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 25, 19 40 to Oct. 20, 19 55 , that I last saw the deceased alive on Oct. 20, 19 55 , and that death occurred at 7:12 P.M. from the causes and on the date stated above.							
SIGNATURE [Signature]		A.M. ADDRESS Cullen, Maryland		DATE SIGNED October 21, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-22-55		NAME OF CEMETERY OR CREMATORY Blue Ridge Cem.		LOCATION (City, town, or county) (State) Thurmont, Md.	
DATE REC'D BY LOCAL REGISTRAR 10/21/55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10/10/10

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9724

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>625 Wilson Place</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> STREET ADDRESS (If rural give location) <u>625 Wilson Place</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HUGH</u> <u>REYNOLDS</u> <u>DEAN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>October 13, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE <u>MARRIED</u> WIDOWED <u>WIDOWED</u> (Specify): <u>Widowed</u>	8. DATE OF BIRTH <u>4 March 1876</u>
9. AGE last birthday <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John A. Dean</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Mainhart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT & ADDRESS: <u>625 Wilson Place, H. Albert Dean, Frederick, Maryland</u>			
15. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE DUE TO (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE (B) DUE TO (B) <u>Chronic hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs</u> <u>10 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1920</u> , to <u>Oct 12, 1955</u> , that I last saw the deceased alive on <u>Oct 12, 1955</u> , and that death occurred at <u>4:45 A</u> M, from the causes and on the date stated above. SIGNATURE <u>A. J. Klein</u> ADDRESS <u>Frederick, Maryland</u> DATE SIGNED <u>13 Oct 1955</u> M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>15 Oct 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>14 Oct 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9754

MARYLAND STATE DEPARTMENT OF HEALTH

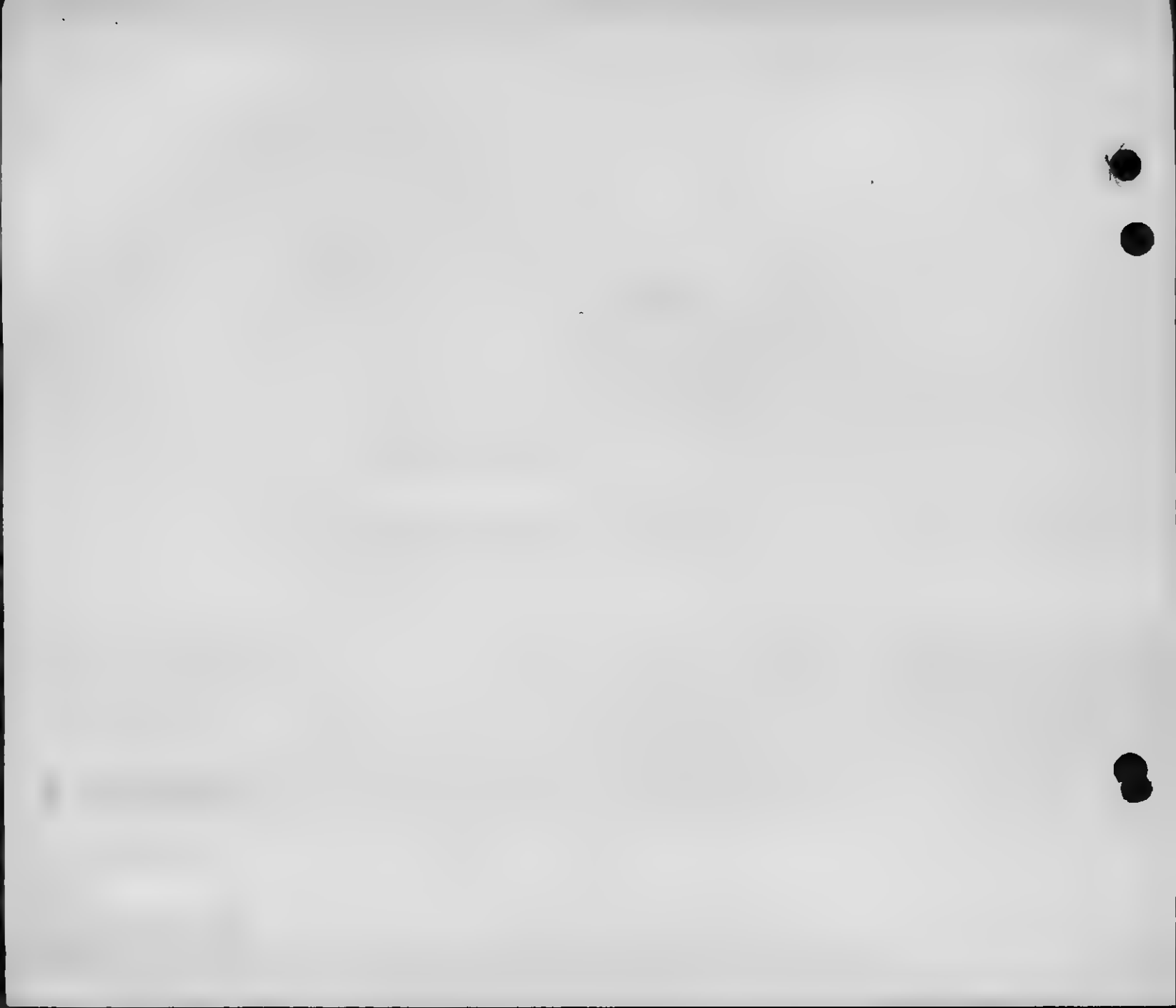
2411 N. Charles Street, Baltimore

09742

CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Frederick-Rural RD#4</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riggs Cottage - e</u> <u>Saxitativu</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural RD#4</u> TOWN <u>Frederick-Rural RD#4</u> STREET ADDRESS <u>Feagaville</u>	
3. NAME OF DECEASED (Type or Print) <u>ANNIE</u> (First) <u>MARY</u> (Middle) <u>Derr</u> (Last)		4. DATE OF DEATH <u>Oct</u> (Month) <u>23</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb 19 1889</u>
9. AGE last birthday <u>66</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Harlan J. Beard</u>		14. MOTHER'S MAIDEN NAME <u>Ann R. Culler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>R. F. D. #4, Miss E. Elizabeth Derr, Frederick, Maryland</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE PRESENT ONSET AND DEATH	
334x Immediate cause (a) <u>Myocardial failure</u>		<u>2 weeks</u>	
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>		<u>unknown</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cerebral arteriosclerosis</u>		<u>10 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u> PLACE (Home, farm, factory, street, office bldg., etc.) <u>Feagaville</u> (CITY OR TOWN) <u>Frederick</u> (COUNTY) <u>Frederick</u> (STATE) <u>Md</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7:00</u> INJURY OCCURRED While at <u>Work</u> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 15, 1955</u> , to <u>Oct 23, 1955</u> , that I last saw the deceased alive on <u>Oct 23, 1955</u> , and that death occurred at <u>7:00</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>Joseph J. Turner</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>Gamsville Md 2355</u> DATE SIGNED <u>Oct 23 1955</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>25 Oct 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	LOCATION (City, town, or county) <u>Frederick, Maryland</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>24-1955</u>	REGISTRAR'S SIGNATURE <u>William A. Tolson</u>	24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u> ADDRESS <u>Frederick, Maryland</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09743

9725

CERTIFICATE OF DEATH

Reg. Dist. No. 131

Item 2, Film G188 11-10-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Frederick		LENGTH OF STAY (in this place) 4 years		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick Unionville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home for the Aged				STREET ADDRESS (If rural give location) Home for the Aged - 115 Record St.			
3. NAME OF DECEASED: (First) ELLA		(Middle) VIRGINIA		(Last) ECKER		4. DATE OF DEATH: (Month) October (Day) 30 (Year) 19 55	
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED , DIVORCED, (Specify): Single		8. DATE OF BIRTH: August 6, 1865	
9. AGE last birthday: 90 yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Seamstress		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William Ecker				14. MOTHER'S MAIDEN NAME: Augusta A. Barnes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.: None		17. INFORMANT & ADDRESS: Mrs. Lillian A. Nicodemus - Unionville, Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X Immediate cause Cerebral Hemorrhage Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO						Interval Between Onset and Death 48 hrs.	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 28 OCT., 1955 , to 30 OCT., 1955 , that I last saw the deceased alive on 30 OCT., 1955 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above. SIGNATURE (Doctor or title) Charles H. Conley, M.D. Frederick, Md. DATE SIGNED 31 OCT. 1955							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Nov. 2, 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR Nov. 1955		REGISTRAR'S SIGNATURE Elizabeth S. Heck		24. FUNERAL DIRECTOR C. E. Cline & Son - Frederick, Maryland			



1 9755

CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Walkersville</u>	<u>47 yrs.</u>	OR TOWN <u>Walkersville</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
10			

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	
CHARLES CLINTON		FOGLE	
(Type or Print)		DATE OF DEATH: <u>October 3</u> 19 <u>55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
M	W	<u>Widowed Nov. 9, 1870</u>	
9. AGE last birthday		10. KIND OF BUSINESS OR INDUSTRY:	
<u>84</u> yrs.		<u>Flour mill</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Francis Fogle</u>		<u>Margaret Irone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>412-14-7154</u>	
17. INFORMANT & ADDRESS:			
<u>Mr. Clyde H. Fogle, 603 Fairview Ave., Fred.</u>			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE		
<u>420.1</u>		
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(A) DUE TO		
<u>CORONARY THROMBOSIS & MYOCARDIAL INFARCTION</u>		<u>9 day</u>
(B) DUE TO		
<u>ARTERIOSCLEROTIC CVD</u>		<u>10, YEARS</u>
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
<u>EMBOLISM, RIGHT BRACHIAL ARTERY</u>		<u>3 day</u>

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 April, 1947, to 3 Oct, 1955, that I last saw the deceased alive on 20 Oct, 1955, and that death occurred at 5:00 P. from the causes and on the date stated above.

SIGNATURE [Signature] M.D. [Signature] ADDRESS Walkersville, Md. DATE SIGNED 4 Oct 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct. 6, 1955</u>	<u>Glade Cemetery</u>	<u>Walkersville, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Oct 4/55</u>	<u>[Signature]</u>	<u>G.C. Barton</u>	<u>Walkersville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 1/2 1/2 1/2 1/2

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9726

CERTIFICATE OF DEATH

Reg. Dist. No. 097431

1 PLACE OF DEATH:

COUNTY Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

11 ~~Frederick~~ Frederick

LENGTH OF STAY (in this place)

30 hrs.

HOSPITAL OR INSTITUTE OR STREET ADDRESS

69 Frederick Memorial Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

Frederick COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR ~~TOWN~~ Rural- Myersville X

STREET ADDRESS

(If rural give location)

Route # 1.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

LULU

MAY

GAVER

4. DATE OF DEATH:

(Month)

(Day)

(Year)

October 6

19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

10. IF UNDER 1 YEAR

Female

White

Widowed

July, 27, 1876

79 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

own home

11. BIRTHPLACE (State or foreign country):

Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Charles Leatherman

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

none

17. INFORMANT & ADDRESS:

Glenn C. Gaver, Myersville, Md., Rt. #1

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work Not While At Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/4, 1955, to 10/6, 1955, that I last saw the deceased

alive on 10/5, 1955, and that death occurred at 12:45 AM

(Degree or title)

from the causes and on the date stated above.

C. L. Lachar, M.D.

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATION

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8 October, 1955

Elizabeth B. Heck

Paul F. Bittle, Myersville, Md.

HARIN RESERVED FOR BINING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09745

9756

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH: COUNTY <u>Frederick</u> OR (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>Frederick</u> OR (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u> STREET ADDRESS <u>111 N. Charles St.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>OTTO</u> <u>Gert</u> <u>H</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11</u> <u>26</u> <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-1-1901</u> 9. AGE last birthday <u>54</u> yrs. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Mins. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>German</u>		13. FATHER'S NAME <u>Heinrich Otto</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Maria</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>1-16-10-1061</u>		17. INFORMANT AND ADDRESS <u>Dr. J. H. ...</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 Immediate cause (a) <u>Coronary Thrombosis</u> Antecedent cause(s) (b) <u>Arteriosclerosis</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 minutes</u> <u>27.25 hr</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		(STATE)	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 16</u> , 19 <u>52</u> , to <u>Oct 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 26</u> , 19 <u>55</u> , and that death occurred at <u>3:45</u> m., from the causes and on the date stated above. SIGNATURE <u>Dr. J. H. ...</u> (Degree or title) ADDRESS <u>...</u> DATE SIGNED <u>Oct 27, 1955</u>			
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>27 Oct. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth H. Heck</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>...</u>	

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1 9757

09746
Reg. Dist.

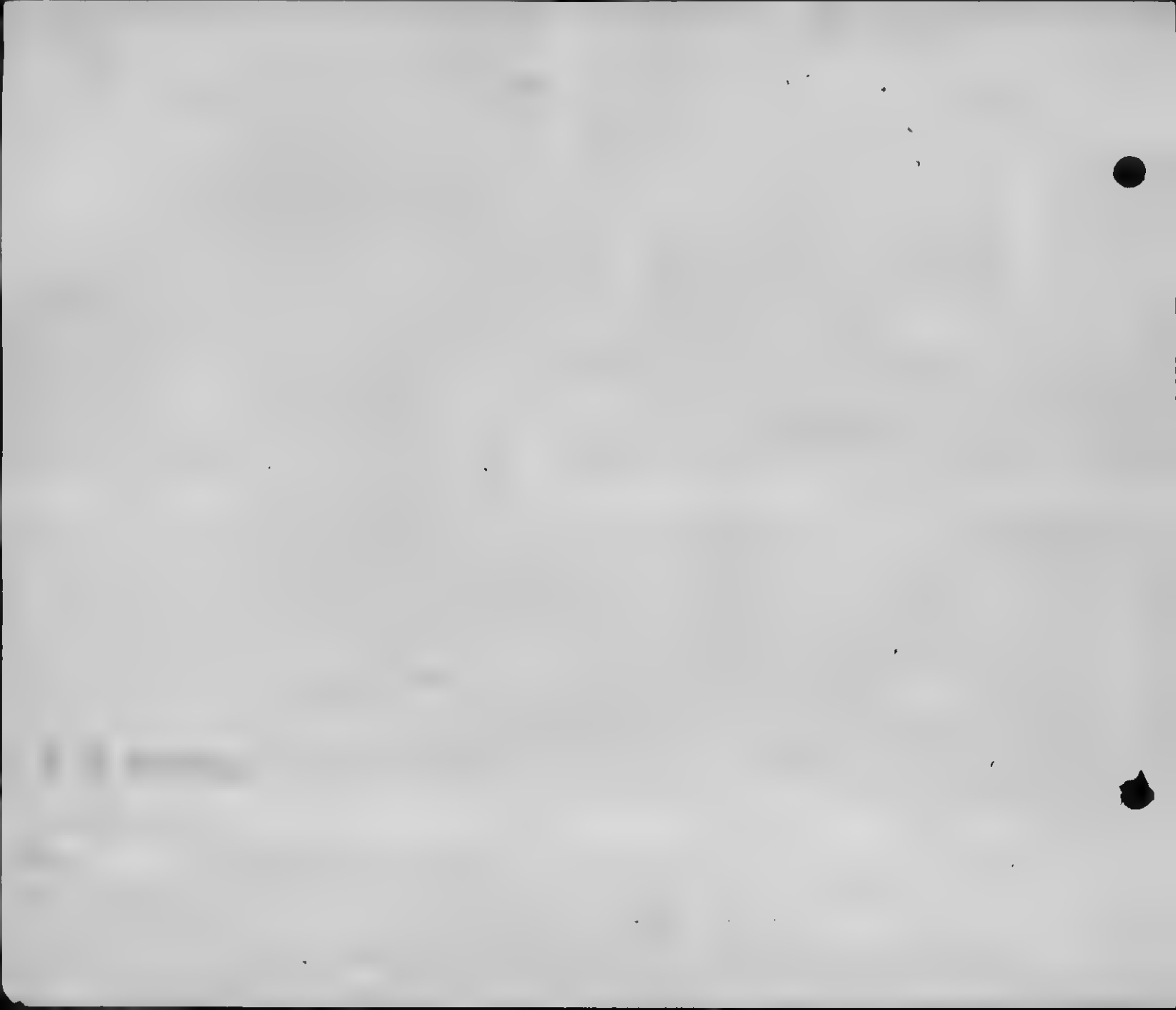
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Died enroute to Hospital	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Frederick-Rural-R.F.D.#6	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) ALGIE	(Middle) LOUIS	(Last) GOINS	(Month) October (Day) 15 (Year) 19 55
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: September 2, 1930
9. AGE last birthday: 25 yrs.		10. BIRTHPLACE (State or foreign country): Virginia	
11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Homer Goins		14. MOTHER'S MAIDEN NAME: Lillie Houndshell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No.: 212-24-5596	
17. INFORMANT & ADDRESS: Mr. Homer Goins, R.F.D.#6, Frederick, Maryland			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		816X	
Immediate cause (a) Broken neck		DUE TO	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		DUE TO	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21c. (City or town) Frederick (County) Md (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 15 1955 45 M.	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Collision of two automobiles	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		DATE SIGNED	
M. D.		M. D.	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Oct. 18, 1955 St. Johns Lutheran Cem		Greagerstown, Maryland	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
17 Oct 1955 Elizabeth G. Heck		M. R. Etchison & Son, Frederick, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9746

CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH:

COUNTY **Frederick**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **Brunswick**LENGTH OF STAY
(in this place)
48 yearsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS**15 West "G"**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland**COUNTY **Frederic**

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **Brunswick**STREET
ADDRESS**15 West "G"**3. NAME OF
DECEASED:

(First)

John

(Middle)

Calvin

(Last)

Grove

4. DATE

(Month)

(Day)

(Year)

OF
DEATH:**10****8****19 55**

5. SEX:

Male6. COLOR OR
RACE:**White**7. SINGLE, MARRIED,
WIDOWED, DIVORCED,**Widowed**

8. DATE OF BIRTH:

5-16-1884

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

71

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of
work done during most of working life,**Retired Engineer**10b. KIND OF BUSINESS OR
INDUSTRY:**B. and O. R. R. Co**

11. BIRTHPLACE (State or foreign country):

Maryland12. CITIZEN OF WHAT
COUNTRY?**U.S.A.**

13. FATHER'S NAME:

Calvin Grove

14. MOTHER'S MAIDEN NAME:

Louise Hankey15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service) **No**

16. SOCIAL SECURITY No.:

705-12-2972

17. INFORMANT & ADDRESS:

Earl A. Grove, Brunswick, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between
Onset And Death**10 hrs**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED

While at

Not While

Work ☐At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from **9/11**, 19**48**, to **10/8**, 19**55**, that I last saw the deceasedalive on **10/6**, 19**55**, and that death occurred at **6 PM**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)**Burial**

DATE THEREOF

10-11-55

NAME OF CEMETERY OR CREMATORY

Reformed

LOCATION (City, town, or county)

Knoxville, Maryland

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

Kathryn H. Brown

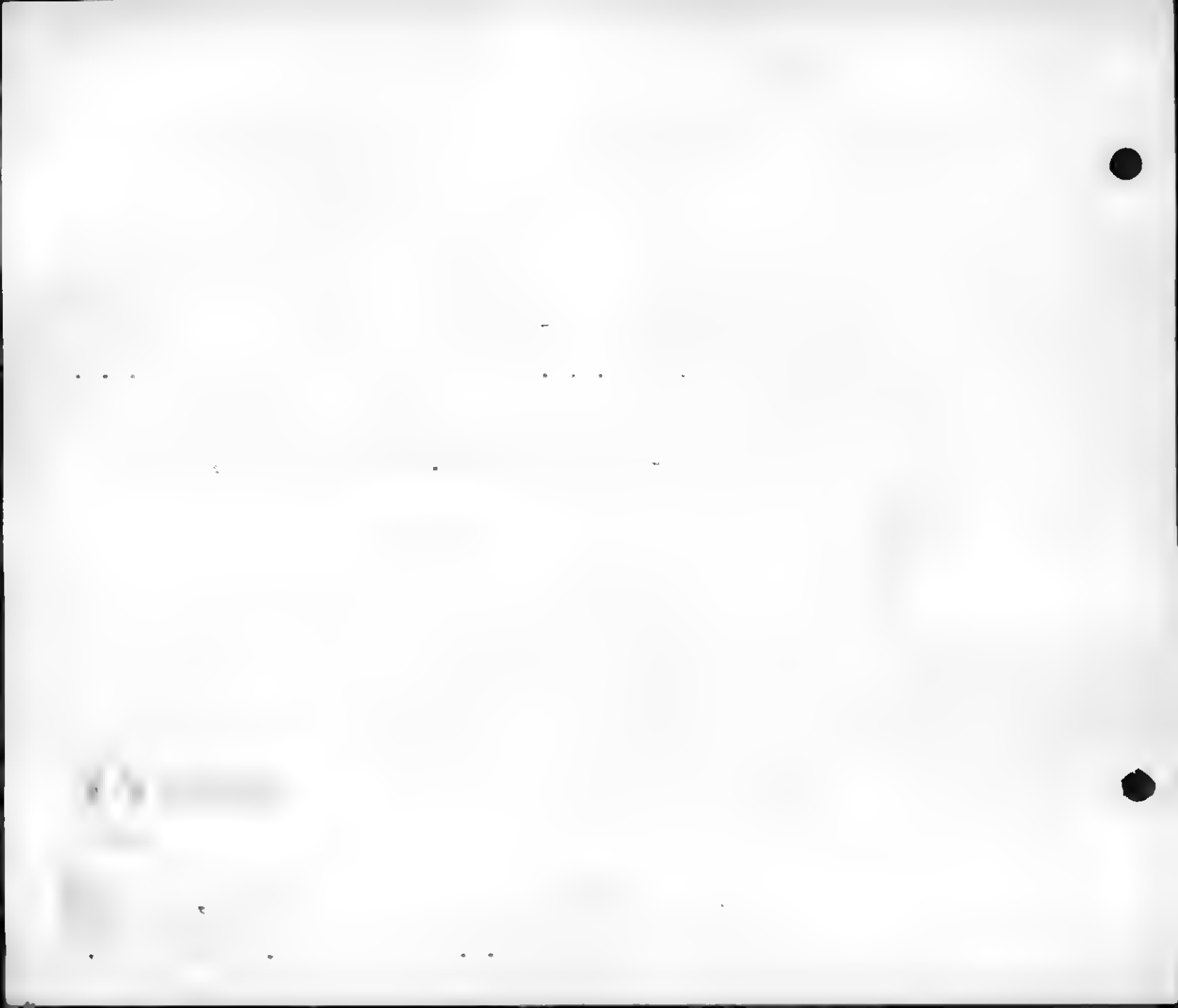
24. FUNERAL DIRECTOR

ADDRESS

C. H. Feete and Bro. Brunswick, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 131

9727

1. PLACE OF DEATH:

COUNTY **F rederick**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

OR **Frederick**

LENGTH OF STAY

(in this place)

LifeHOSPITAL OR
INSTITUTION OR
STREET ADDRESS**315 Madison Street**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland**COUNTY **Fred.**

CITY (If outside corporate limits, write RURAL and give nearest town)

OR **Frederick**STREET
ADDRESS

(If rural give location)

315 Madison Street3. NAME OF
DECEASED:

(First)

Mary

(Middle)

Elizabeth

(Last)

Hall

(Type or Print)

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

10 19**19 55**

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, ~~Separated~~(Specify): **widowed**

8. DATE OF BIRTH:

Aug. 26, 1960

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

95

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired): **Housewife**10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Frederick Co.12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)**No**

16. SOCIAL SECURITY NO.:

None

17. INFORMANT & ADDRESS:

Charles E. Hall 315 Madison St. Fred. Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
Immediate cause(a) **Acute cardiac failure**
DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.(b) **Hypertension**
DUE TO(c) **Generalized arteriosclerosis**Interval Between
Onset And Death**3 mos****yr?****yr?**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/2

10/3, to 10/18, 1955, that I last saw the deceased

alive on 10/18, 1955, and that death occurred at

SIGNATURE

(Degree or title)

8:25 PM

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

10-21-55**St Johns****Frederick****Md.**DATE RECD BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

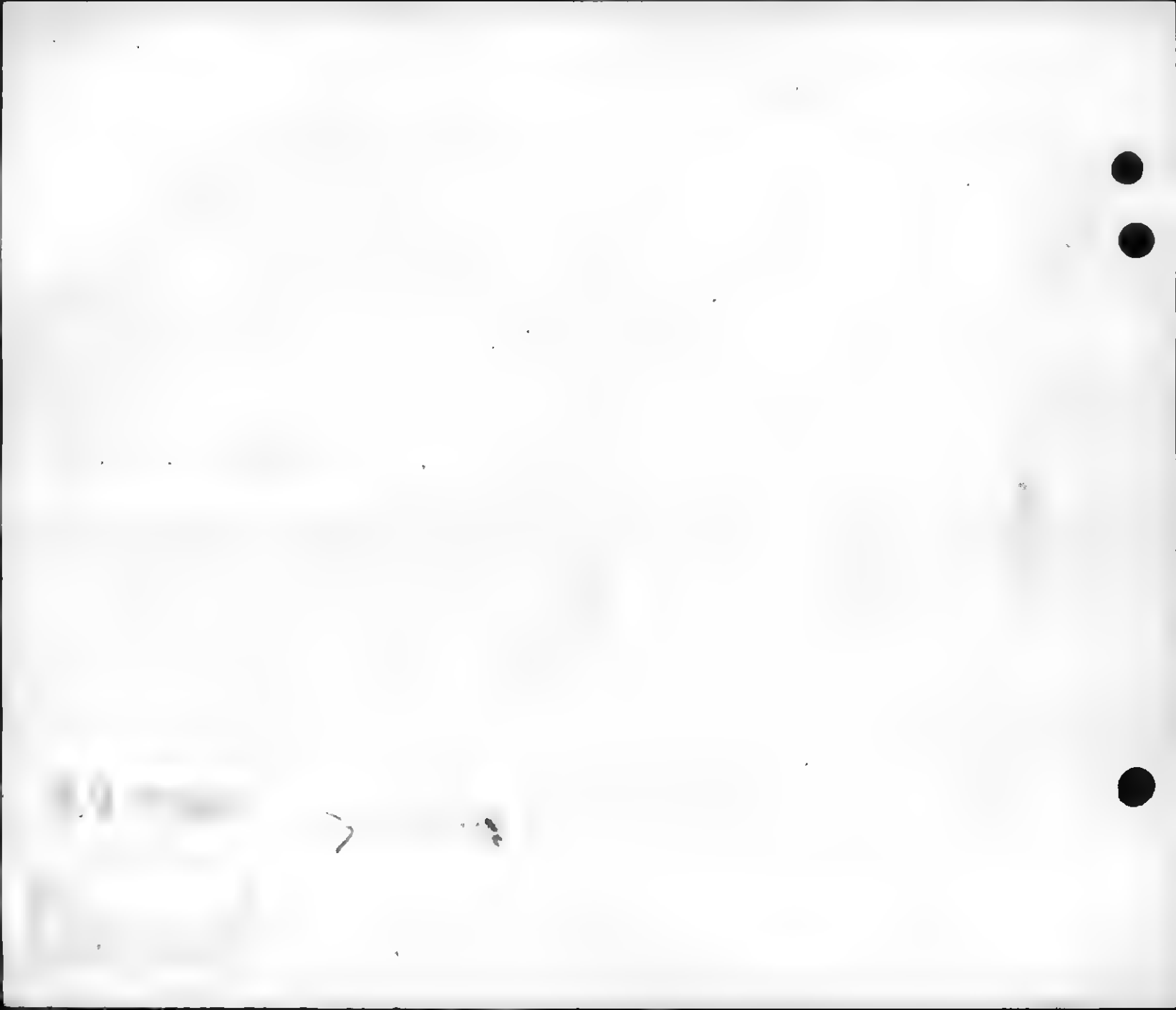
24. FUNERAL DIRECTOR

ADDRESS

21 Oct. 1955**Elizabeth B. Heck****Charles E. Hicks III Frederick, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
are is especially important. Physicians: please write the causes of death clearly and legibly.



9728

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

COUNTY Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Frederick

LENGTH OF STAY
(in this place)

55 years

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

410 North Bentz Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY Frederick

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Frederick

STREET
ADDRESS

(If rural give location)

410 North Bentz Street

3. NAME OF
DECEASED:

(First)

SHIRLEY

(Middle)

GILBERT

(Last)

HALLER

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

October 23 1955

5. SEX:

Female

6. COLOR OR
RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

Widowed

8. DATE OF BIRTH:

August 25, 1895

9. AGE last birthday:

60 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of
work done during most of working life,
even if retired):

Housewife

10b. KIND OF BUSINESS OR
INDUSTRY:

Own home

11. BIRTHPLACE (State or foreign country):

Pennsylvania

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME:

Olivet Cleveland Gilbert

14. MOTHER'S MAIDEN NAME:

Dovie Clem

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

No

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Mrs. Millard G. Wireman - Frederick, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause

(a) DUE TO

Cerebral hemorrhage

Antecedent causes(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b) DUE TO

(c)

Interval Between
Onset And Death

10 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 20, 1955, to Oct. 30, 1955, that I last saw the deceased

alive on Oct. 20, 1955, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL
BURIAL (Specify)

DATE THEREOF

Oct. 26, 1955

NAME OF CEMETERY OR CREMATORY

Mount Olivet Cemetery

LOCATION (City, town, or county)

Frederick,

(State)

Maryland

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

Elizabeth G. Hech

24. FUNERAL DIRECTOR

C. E. Cline & Son - Frederick, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9729

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (In this place) <u>12 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>Rowle #5</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Judy Ann Hanshaw</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>October 18 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>October 18, 1915</u>	
9. AGE last birthday: <u>40</u> yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>INFANT</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <u>Floyd Marshall Hanshaw Sr.</u>			
14. MOTHER'S MAIDEN NAME: <u>Carrie Anna Kemp</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO.: <u>NONE</u>				17. INFORMANT & ADDRESS: <u>mother - Frederick Rt #5</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Citellactasis</u>						<u>1/2 hour</u>	
ANTECEDENT CAUSE (B) <u>Chondrodystrophia fetalis</u>						<u>at birth</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 18, 1955</u> , to <u>Oct. 18, 1955</u> , that I last saw the deceased alive on <u>Oct. 18, 1955</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>B. J. Thomas</u>				ADDRESS <u>M. D. Frederick Md</u> DATE SIGNED <u>Oct. 18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>19 OCT 1955</u>		NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET CEMETERY</u>		LOCATION (City, town, or county) (State) <u>FREDERICK, MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>19 Oct 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. ETCHISON & SON, FREDERICK, MD</u>			

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10534741

W. A. WILSON

OCT 2 1900

107 A DEPT 1

9758

CERTIFICATE OF DEATH

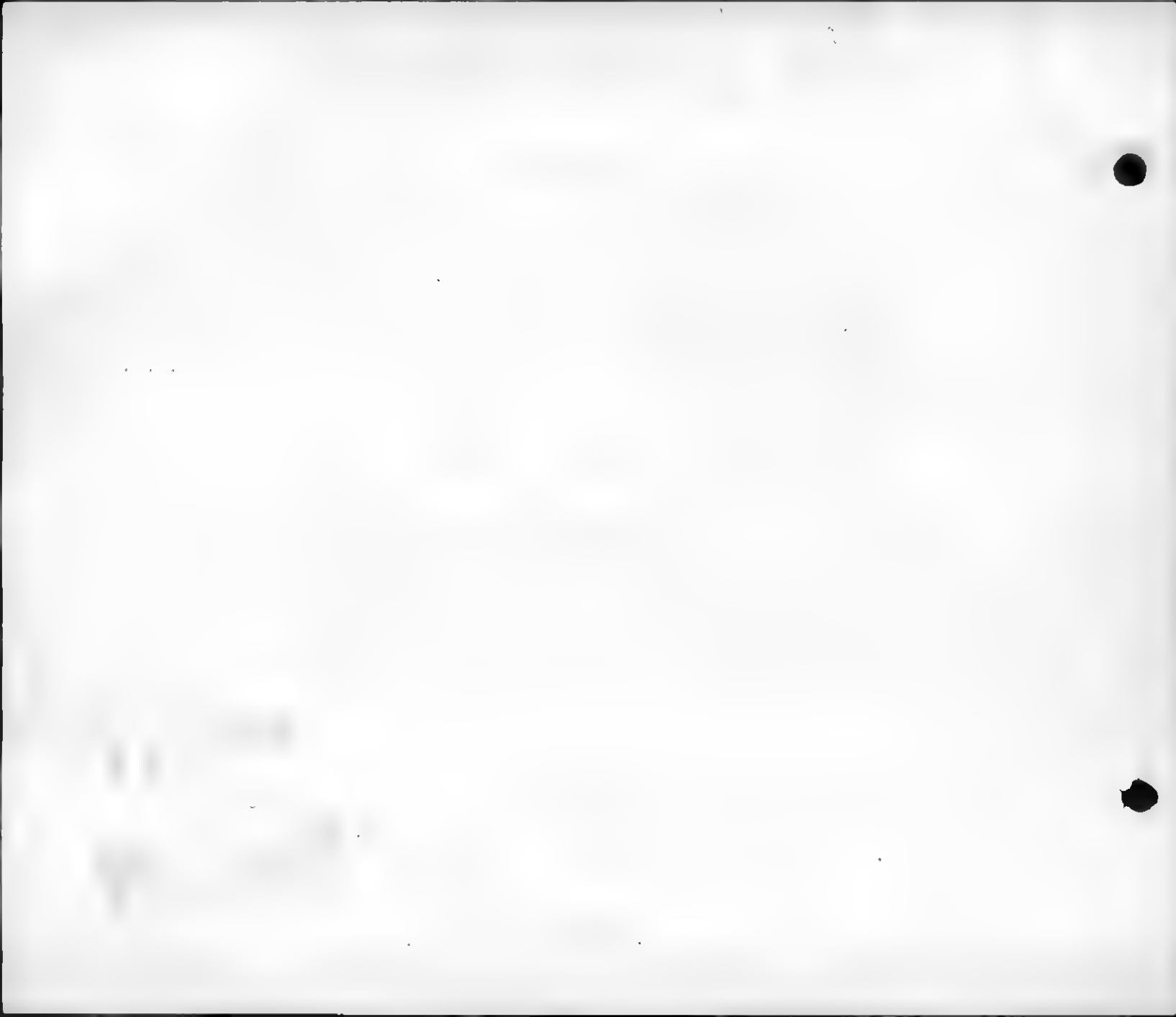
Reg. Dist. No. 139

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Allegany
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cullen	LENGTH OF STAY (in this place) 10 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland 01-02-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital		STREET ADDRESS (If rural give location) 109 N. Chase Street	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) Edmund	(First) Joseph	(Last) Kean, Jr.	OF DEATH Oct. 23 1955
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 8/29/1928
9. AGE last birthday: 27 yrs.		10. BIRTHPLACE (State or foreign country): Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Edmund Joseph Kean, Sr.		14. MOTHER'S MAIDEN NAME: Nancy Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) Korean War		16. SOCIAL SECURITY NO. 216-22-5233	
17. INFORMANT & ADDRESS: Patient.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis		11 months.	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 13, 1955 , to Oct. 23, 1955 , that I last saw the deceased alive on Oct. 23, 1955 , and that death occurred at 6:10 M. from the causes and on the date stated above.			
SIGNATURE W. D. Kean		DATE SIGNED October 24, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/26/55	
NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem.		LOCATION (City, town, or county) (State) Cumberland, Allegany, Md.	
DATE REC'D BY LOCAL REGISTRAR 10/24/55		24. FUNERAL DIRECTOR ADDRESS George Funeral Home, Cumberland, Md.	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

9730

CERTIFICATE OF DEATH

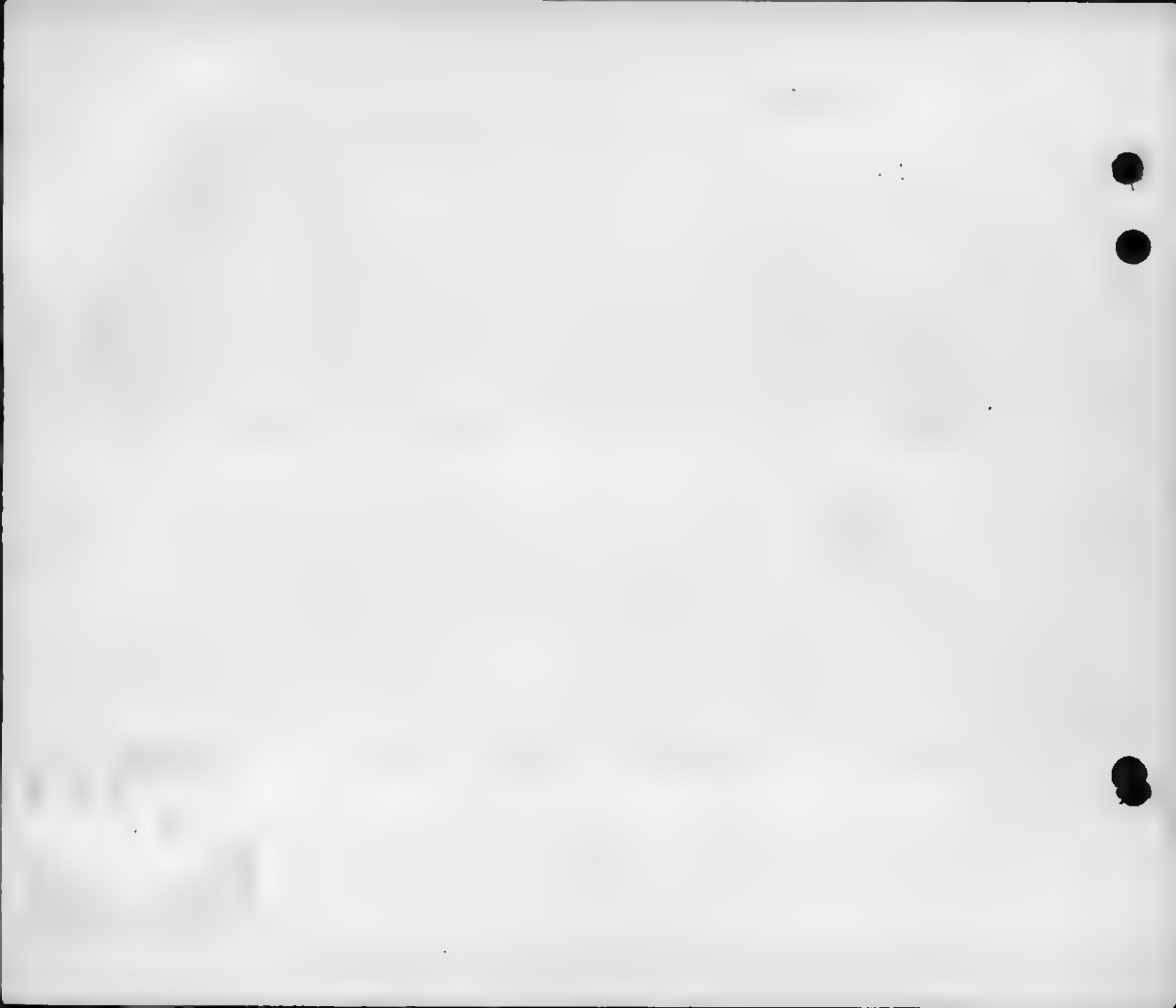
FOR MEDICAL EXAMINERS

09753

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Apt. 5-C Watkins Acres		STREET ADDRESS (If rural, give location) Apt. 5-C Watkins Acres	
3. NAME OF DECEASED (Type or Print)	(First) HELEN (Middle) MILDRED (Last) KEATS	4. DATE OF DEATH (Month) (Day) (Year) October 31, 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 21 Oct 1893
9. AGE last birthday 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Bollinger		14. MOTHER'S MAIDEN NAME Anna Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Apt. 5-C Watkins Acres Frederick, Maryland		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<p>977X Immediate cause (a) Hemorrhage</p> <p>Antecedent cause(s) (b) Caused by lacerations of neck on both sides - Safety razor inflicted</p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>		5 months	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work Not while at work	
22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [] accident [] suicide [] homicide [] undetermined []		HOW DID INJURY OCCUR?	
SIGNATURE		DATE SIGNED	
23. BIRTH, CREMATION, or BURIAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State)	
31 October 1955		Cedar Hill Crematory Suitland, Maryland	
24. FUNERAL DIRECTOR		ADDRESS	
M. R. Etchison & Son, Frederick, Maryland			



9731

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> OR <u>TOWN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>705 Motter Avenue</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> OR <u>TOWN</u> STREET ADDRESS (If rural give location) <u>705 Motter Avenue</u>	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>LUDWIG</u> <u>HENRY</u> <u>KERN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>October 15,</u> <u>19</u> <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>October 2, 1888</u>
9. AGE last birthday <u>67</u> yrs.		10. AGE UNDER 1 YEAR Months Days Hours Min.	11. AGE UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Adam Kern</u>	
14. MOTHER'S MAIDEN NAME: <u>Freda Derringer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u> <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-18-0744</u>		17. INFORMANT & ADDRESS: <u>705 Motter Avenue, Mrs. Hattie S. Kern, Frederick, Maryland</u>	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Pneumonia</u> ANTECEDENT CAUSE (B) <u>Pulmonary Emphysema</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 years</u> <u>2 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 1, 1953</u> , to <u>15 Oct., 1955</u> , that I last saw the deceased alive on <u>15 Oct., 1955</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Shuman E. Stone</u> ADDRESS <u>Frederick, Maryland</u> DATE SIGNED <u>10-17-1955</u> M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 18, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>17 Oct 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COMPTON V. S.

OCT 19 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9759

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09755
Reg. Dist.

No. 131

1. PLACE OF DEATH: COUNTY <u>Frederick</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Town Frederick-Rural R.D.#5,</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bower's Road</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Frederick-Rural-R.D.#5</u> STREET ADDRESS (If rural, give location) <u>Bower's Road</u>									
3. NAME OF DECEASED: (Type or Print) <u>Melvin</u> (First) <u>IRA</u> (Middle) <u>Kline</u> (Last)		4. DATE OF DEATH <u>October 19,</u> 19 <u>55</u> (Month) (Day) (Year)		5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED , (Specify): <u>Widower</u>		8. DATE OF BIRTH: <u>April 5, 1899</u>		9. AGE last birthday: <u>56</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Farm Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>				11. BIRTHPLACE (State or foreign country): <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles D. Kline</u>						14. MOTHER'S MAIDEN NAME: <u>Iola Ann Rebecca Kline</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		(If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mr. C. Milton Kline, Frederick, R.D.#5, Md.</u>							
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>974X</u> Immediate cause (a) <u>Stangulation</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO stating underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.												INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:								20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY				21c. (City or town) (County) (State)					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>James B. Thomas</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/19/55</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>													
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>22 Oct 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rocky Springs Cemetery</u>				LOCATION (City, town, or county) (State) <u>Nr. Frederick, Maryland</u>			
DATE REC'D BY LOCAL REG. <u>21 October 1955</u>				REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>				24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>				ADDRESS	



9732

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:

COUNTY Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
OR FrederickLENGTH OF STAY
(in this place)
2 weeksHOSPITAL OR
INSTITUTION OR
STREET ADDRESS Frederick Memorial

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md

COUNTY Frederick

CITY (If outside corporate limits, write RURAL and give nearest town)
OR Rural CreagerstownSTREET ADDRESS (If rural give location)
/

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Nettie

Rebecca

Kolb

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

4. DATE OF DEATH:

(Month)

(Day)

(Year)

October 8

1955

Female

White

Widowed

Mch. 18. 1884

71

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired
Housewife10b. KIND OF BUSINESS OR INDUSTRY:
Own Home11. BIRTHPLACE (State or foreign country):
Maryland12. CITIZEN OF WHAT COUNTRY?
U. A.

13. FATHER'S NAME:

George S. Ramsburg

14. MOTHER'S MAIDEN NAME:

Elenoir Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)
No(If Yes, give war or dates of service)
No16. SOCIAL SECURITY No.:
No

17. INFORMANT & ADDRESS:

Mrs Norman Burdette Rocky Ridge MD

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

268X
Immediate cause

(a) Acute coronary thrombosis

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Arteriosclerotic heart disease
Diabetes mellitus

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/26, 1955, to 10/8, 1955, that I last saw the deceased alive on 10/8, 1955, and that death occurred at 10:30 p.m., from the causes and on the date stated above.
SIGNATURE A. C. Gasser M.D. ADDRESS Frederick, Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

10 October 1955 Elgin L. Herb

M.L. Creager & Son. Thurmont. Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 Q9757
 No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Frederick</u>	
OR (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		OR (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Libertytown</u>		<u>8 yrs</u>		TOWN <u>Libertytown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Libertytown Road Route 26</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>Sarah Catherine Della Long</u>				(Month) (Day) (Year) <u>Oct. 2 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Oct. 9, 1889</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Housewife at home</u>				<u>at home</u>		<u>Frederick Co</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Philip Keene</u>				<u>Anna Barbara Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>no</u>		<u>Harvey A. Long Libertytown Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause		(a) <u>Coronary Occlusion</u>				<u>5 minutes</u>	
Antecedent cause(s)		(b) <u>Hypertension</u>				<u>14 yrs &</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
				<u>Home</u>		<u>Libertytown Frederick Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				DATE SIGNED			
<u>B. Thomas M.D.</u>				<u>Oct. 2-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):				NAME OF CEMETERY OR CREMATORY			
<u>Libertytown</u>				<u>Libertytown</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR, ADDRESS			
<u>Oct 3/55 Elizabeth H. Heck</u>				<u>Libertytown, Md.</u>			

7 11-11-11

11-11-11

9761

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Pa</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Rural - Frederick</u>	<u>15 yrs</u>	TOWN <u>Holmes</u>	<u>10-1</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shookstown Road</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>William</u>	(Middle) <u>MARTIN</u>	(Last) <u>McGrew</u>	OF DEATH: <u>Oct. 20</u> 19 <u>55</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec. 26 1877</u>
9. AGE last birthday <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Roofer</u>	
11. KIND OF BUSINESS OR INDUSTRY: <u>own business</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Martin McGrew</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Susan Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>215-26-1145</u>	
17. INFORMANT & ADDRESS: <u>Holmes, Pa.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arterio sclerotic Cardio-vascular disease</u>		<u>10 years</u>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>53</u> , to <u>Oct. 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 20</u> , 19 <u>55</u> , and that death occurred at <u>7:50 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Bernard O. Thomas Jr.</u>		DATE SIGNED <u>Oct 22, 1955</u>	
23. BURIAL, CREMATION, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 24/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		LOCATION (City, town, or county) <u>Woodboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>22 Oct. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	
24. FUNERAL DIRECTOR <u>J.C. Barton, Walkersville, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-100000

100

100

9733

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Frederick</u>
CITY (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	LENGTH OF STAY (in this place) <u>18 da</u>	OR if outside corporate limits, write RURAL and give nearest town <u>Creagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fredk. Mem. Hospital</u>	STREET ADDRESS (if rural give location) <u>1</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CLARA BELL Norris</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 24 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Aug 8, 1885</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday: <u>70</u> yrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Spicer</u>		14. MOTHER'S MAIDEN NAME: <u>Anna Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>8-09-005513</u>	
17. INFORMANT & ADDRESS: <u>Andrew H. Norris Thurmont R.D.I. Md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>422.1</u>		<u>2 wks.</u>	
ANTECEDENT CAUSE (B): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(A) <u>Cerebral Thrombosis - hemiplegia</u> DUE TO <u>right side</u>	
		(B) <u>Arteriosclerotic Cardiovascular</u> DUE TO <u>Disease</u>	
		(C) <u>Pneumonia, Bilateral - Friedlander's</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/6/55</u> , 19 <u>55</u> , to <u>10/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/24</u> , 19 <u>55</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Charles E. Creager</u>		DATE SIGNED <u>10/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 27, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>		LOCATION (City, town, or county) (State) <u>Thurmont, Fredk. Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>27 October 1955</u>		REGISTRAR'S SIGNATURE <u>Eligible G. Heck</u>	
24. FUNERAL DIRECTOR <u>M.L. Creager & Son, Thurmont, MD</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9762

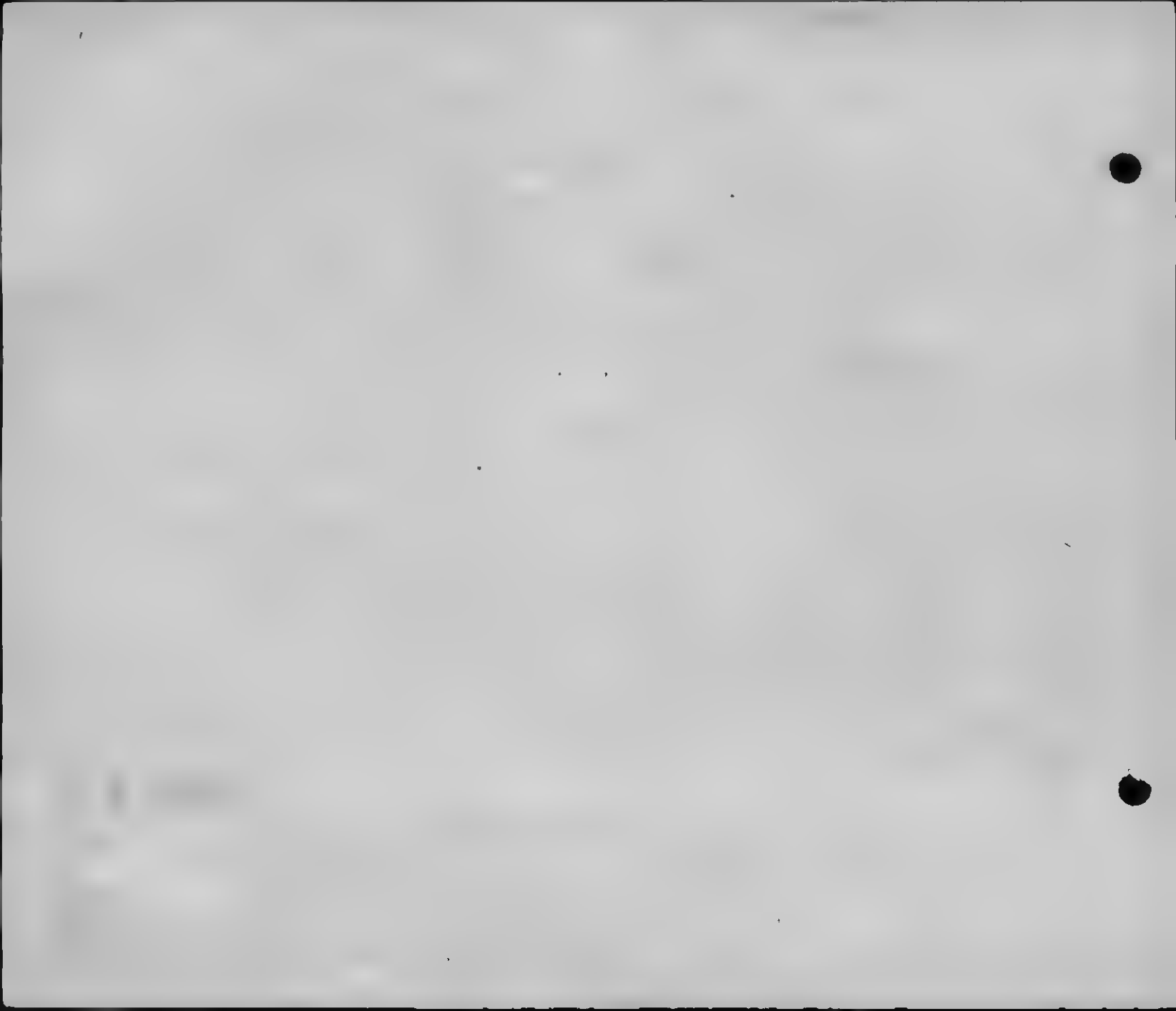
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09759
Reg. Dist.

No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN $\frac{1}{2}$ Mile South of Rt. #40		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Jefferson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS George Wiles Road				STREET ADDRESS (If rural, give location) /			
3. NAME OF DECEASED: (First) RONALD		(Middle) THOMAS		(Last) ODEN		4. DATE OF DEATH October 14, 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: October 24, 1913	9. AGE last birthday: 41 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY: Const. Co.		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas D. Oden				14. MOTHER'S MAIDEN NAME: Fannie Zepp			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		(If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.: 215-20-8856		17. INFORMANT & ADDRESS: Mrs. Kathleen K. Oden, Jefferson, Maryland	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <i>Fracture base of skull</i> DUE TO <i>Fracture right side of skull</i> Antecedent cause(s) (b) <i>Crushed ribs both on left & right side</i> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						<i>Instantaneous</i>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Highway</i>		21c. (City or town) Frederick		(County) Md	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/14/1955 4:30 P.M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Car & Truck ran over chest</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>B. C. Fannon</i>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/14/55		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Oct. 17, 1955		NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		LOCATION (City, town, or county) Frederick, Maryland	
DATE REC'D BY LOCAL REG 17 October 1955		REGISTRAR'S SIGNATURE <i>Elyth G. H. H.</i>		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	



9734

09760
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 146

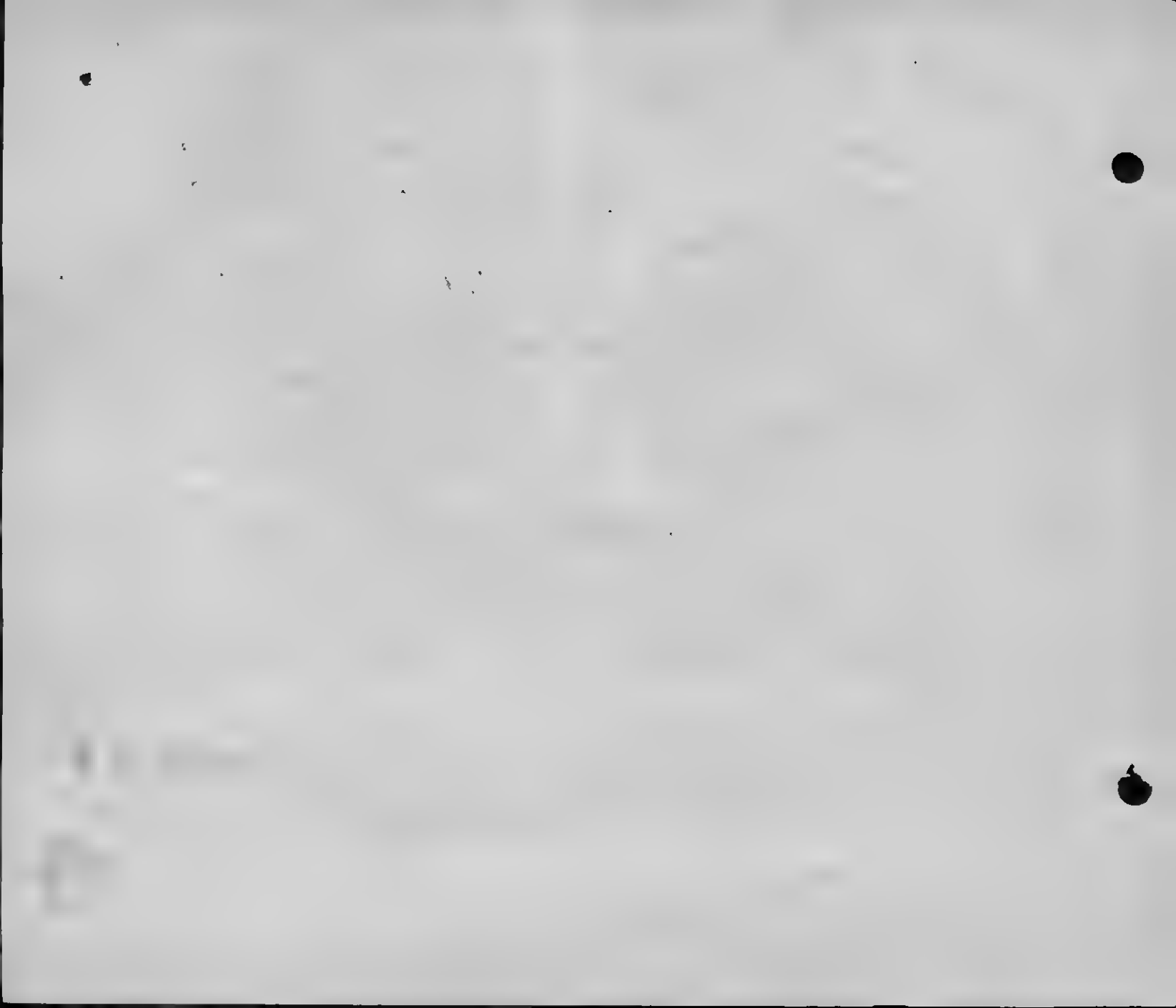
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <i>Frederick</i>	<i>Life</i>	TOWN <i>Frederick R.D. 2</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural, give location)
<i>Frederick Memorial Hospital</i>		<i>1</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First)	(Middle)	(Month)	(Day) (Year)
<i>May AGNES Quirk</i>		<i>October 8 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>Female</i>	<i>White</i>	<i>Single</i>	
9. AGE last birthday:		10. IF UNDER 1 YEAR	
<i>52</i> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
<i>Housework</i>		<i>Employed</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>James Quirk</i>		<i>Mary Morgan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No:	
<i>No</i>		<i>212-24-5654</i>	
17. INFORMANT & ADDRESS:			
<i>Dr. R. Colbert, Woodstock, Md.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) ...	<i>Encephalitis</i>	<i>13 hours</i>
DUE TO		
Antecedent cause(s) (b) ...	<i>Virus infection</i>	<i>18 hrs.</i>
Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Bothman, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>Oct. 8, 1955</i>
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE THEREOF <i>10/11/55</i>	NAME OF CEMETERY OR CREMATORY <i>Rocky Hill</i>	ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
LOCATION (City, town, or county) (State) <i>Woodstock, Md.</i>		
DATE REC'D BY LOCAL REG. <i>10/10/55</i>	REGISTRAR'S SIGNATURE <i>C. L. ...</i>	24. FUNERAL DIRECTOR ADDRESS <i>L. C. Barton, Walkersville, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

09761

9735

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hosp</u>		STREET ADDRESS (If rural, give location) <u>305 Braddock Lane</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Margaret</u> (Middle) <u>Kulla</u> (Last) <u>Ramsburg</u>		4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>3/4/1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>70</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
13. FATHER'S NAME <u>John W. Bowers</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Barker</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>John L. Ramsburg Jr</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4200 Immediate cause (a) <u>Arteriosclerotic Heart Disease with Congestive failure</u>		<u>1 day</u>
Antecedent cause(s) (b) <u> </u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u> </u>		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. <u>Pneumonia, bilateral</u>		<u>2 days</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u> </u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u> </u>	(CITY OR TOWN) <u> </u> (COUNTY) <u> </u> (STATE) <u> </u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u> </u>

22. I hereby certify that I attended the deceased from....., 19....., to 10/3, 1955, that I last saw the deceased alive on 10/3, 1955, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>10/5/55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	LOCATION (City, town, or county) <u>Frederick, Frederick Co</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG <u>4 Oct. 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	24. FUNERAL DIRECTOR <u>R. E. Butler</u>		ADDRESS <u>Frederick, MD</u>	

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE A. J. JONES

CO.



9736

CERTIFICATE OF DEATH

Reg. Dist. No. 131

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information—carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>FREDERICK</u>	MARYLAND	STATE <u>KENTUCKY</u>	COUNTY <u>LETCHER</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>11 TOWN FREDERICK</u>	LENGTH OF STAY (in this place) <u>5 DAYS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR Whitesburg</u>	<u>55X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 Frederick Mem. Hosp.</u>		STREET ADDRESS (If rural give location) <u>✓</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>ALBERT</u>	(Middle)	(Last) <u>ROSS</u>	OF DEATH: <u>October 28 1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>12-15-1900</u>
9. AGE last birthday: <u>54</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>COAL MINER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>COAL MINE</u>	
11. BIRTHPLACE (State or foreign country): <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Sleying Ross</u>		14. MOTHER'S MAIDEN NAME: <u>MARGARET NEWMAN</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>UNK</u>		16. SOCIAL SECURITY NO.: <u>UNK</u>	
17. INFORMANT & ADDRESS: <u>Ms. Virginia Hewitt Poolesville Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
451X IMMEDIATE CAUSE (A) <u>Toxemia</u>		5 days	
ANTECEDENT CAUSE (B) <u>Gas gangrene infection</u>		7 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic pressure necrosis of sacrum</u>		6 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Paraplegia</u>		6 years	
19A. DATE OF OPERATION: <u>U</u>		19B. MAJOR FINDINGS OF OPERATION: <u>U</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>23 Oct</u> , 1955, to <u>28 Oct</u> , 1955, that I last saw the deceased alive on <u>28 Oct</u> , 1955, and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Melvin E. Lea M.D.</u>		ADDRESS <u>2801 14th St N.W. Washington, D.C.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10-29-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Whitesburg, Kentucky</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>10-28-55</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	
24. FUNERAL DIRECTOR <u>The S. D. Hines Co.</u>		ADDRESS <u>2801 14th St N.W. Washington, D.C.</u>	

品 150000

9737

MARYLAND STATE DEPARTMENT OF HEALTH

09763

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7 North Market Street		STREET ADDRESS 144 B & O Avenue	
3. NAME OF DECEASED (Type or Print)	(First) ROBERT	(Middle) GREGORY	(Last) SCHILL
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH November 17, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor & Repairman		10b. KIND OF BUSINESS OR INDUSTRY Board of Education	9. AGE last birthday 51 yrs.
13. FATHER'S NAME John E. Schill		11. BIRTHPLACE (State or foreign country) Maryland	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		10. DATE OF DEATH October 10 1955	
17. INFORMANT AND ADDRESS Mrs. John E. Cooper - Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

5 minutes

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMAINS (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

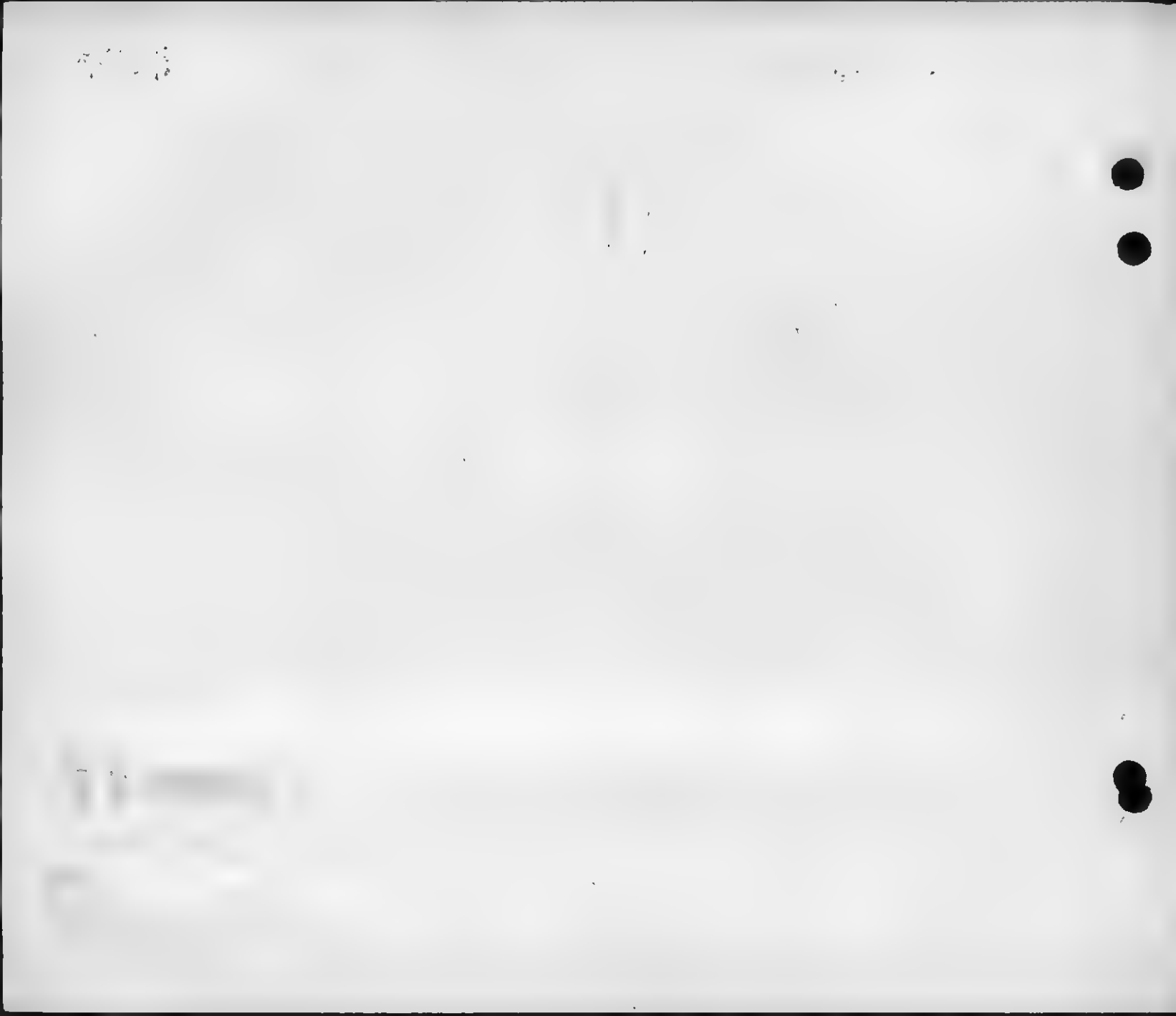
ADDRESS

12 October 1955 Elizabeth B. Heck

C. E. Cline & Son - Frederick, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

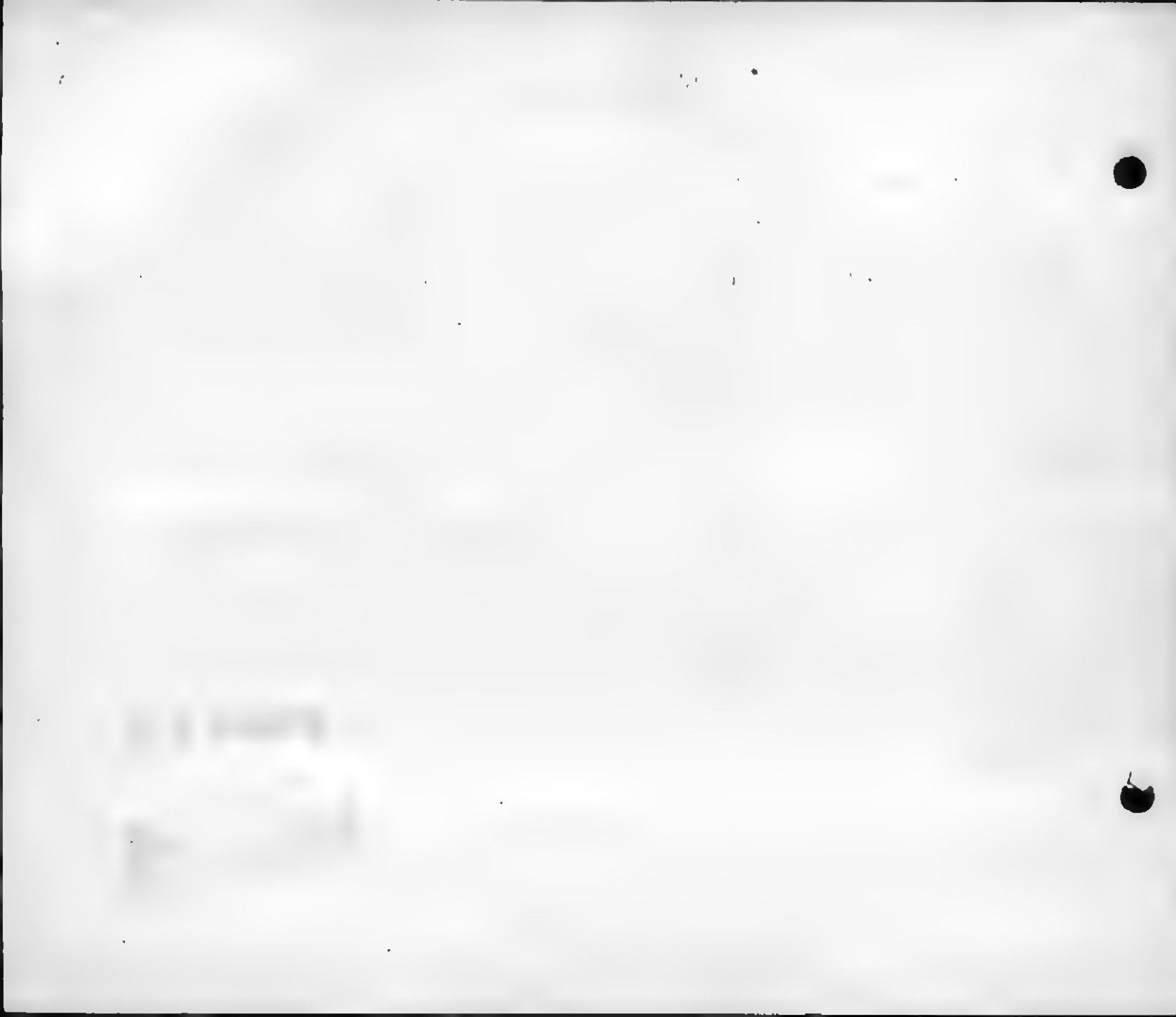
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9738

CERTIFICATE OF DEATH

Reg. Dist. No. 131 09764

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Md		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		LENGTH OF STAY (in this place) 5 da		CITY (If outside corporate limits, write RURAL and give nearest town) Emmitsburg Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) MARY LOUISE SELTZER				4. DATE (Month) (Day) (Year) OF DEATH: Oct. 23. 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED: Married		8. DATE OF BIRTH: July 16th 1890	
9. AGE last birthday: 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Penna.	
13. FATHER'S NAME: Alexander Knott				14. MOTHER'S MAIDEN NAME: Annie Bowman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No				16. SOCIAL SECURITY NO.: No			
17. INFORMANT & ADDRESS: J. Edward Seltzer Emmitsburg R.D. Md				12. CITIZEN OF WHAT COUNTRY? U.S.A			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Generalized Carcinomatosis						6 mos.	
ANTECEDENT CAUSE (B) (Primary site undetermined)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pathological Fracture Femur, left.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 18 Oct, 1955 , to 23 Oct, 1955 , that I last saw the deceased alive on 23 Oct, 1955 , and that death occurred at 10:40 AM , from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 26th. 1955		St. Anthony Cem.		St. Anthony Fredk. Co. Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
25 Oct 1955		Elizabeth H. Heck		M. L. Greager & Son		Thurmont Md	



9739

09765

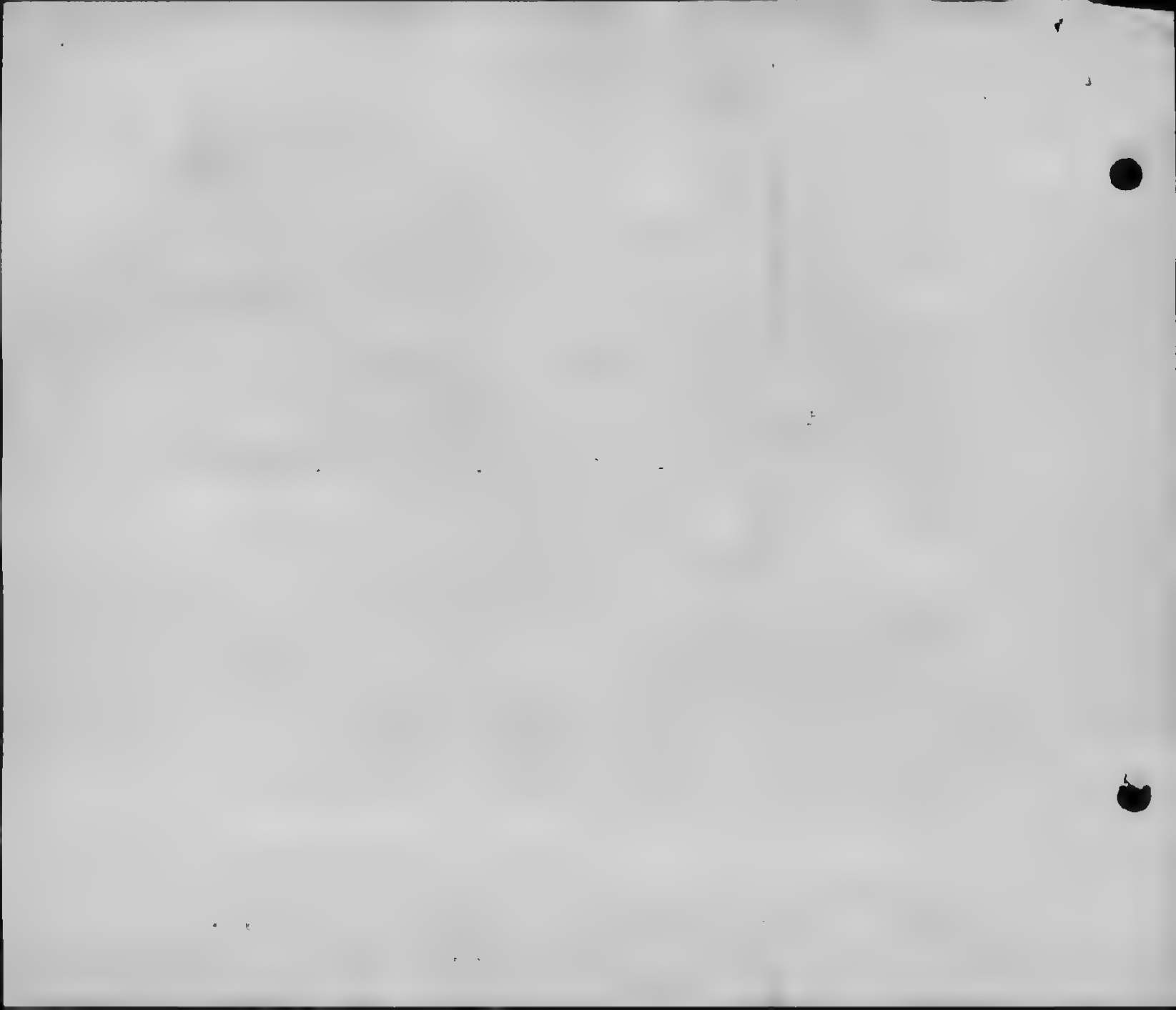
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Frederick</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Boyd's</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Hospital</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Edw</u>		(Middle) <u>H.</u>		(Last) <u>Simpson</u>		(Month) (Day) (Year) <u>Oct 15 1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>8/27/1883</u>	
9. AGE last birthday: <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm Owner</u>		9. AGE last birthday: <u>72</u> yrs.	
11. BIRTHPLACE (State or foreign country): <u>Dayton, Md</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <u>Hamilton H. Simpson</u>				14. MOTHER'S MAIDEN NAME: <u>Laura B. Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY No.: <u>214-30-2230</u>		17. INFORMANT & ADDRESS: <u>Mrs. Walter Brown, Dayton, Md</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
423.2 Immediate cause (a) <u>Coronariafectis</u> DUE TO						2 hrs.	
Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>13</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct 15-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Providence</u>		LOCATION (City, town, or county) (State) <u>Clonell, Md.</u>	
DATE REC'D BY LOCAL REG <u>10/18/55</u>		REGISTRAR'S SIGNATURE <u>AW Hedrick</u>		24. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9740

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Pennsylvania</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town), OR <u>Frederick</u>		LENGTH OF STAY (in this place) <u>40 days</u>		OR <u>Litrope</u>		<u>Box 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Three Pines Nursing Home</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CARROLL LEE SMITH</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 18</u> 19 <u>55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 4, 1875</u>	9. AGE last birthday <u>80</u> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>own business</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>James P. Smith</u>				14. MOTHER'S M maiden NAME: <u>Alice Barrick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Mr. John A. L. Smith, 1018 Church St., Fred., Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bacterial pneumonia</u>						<u>3 weeks</u>	
ANTECEDENT CAUSE (B) <u>Malignancy, metastasizing, type unknown</u>						<u>months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 30, 1955</u> , to <u>Oct. 18, 1955</u> , that I last saw the deceased alive on <u>Sept 30</u> , 1955, and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert L. Turner, Jr.</u>				ADDRESS <u>7 E. Church St. Frederick, Md.</u>		DATE SIGNED <u>10-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Int. Hope</u>		LOCATION (City, town, or county) (State) <u>Woodboro Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>19 October 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		24. FUNERAL DIRECTOR <u>J.C. Barton, Walkersville</u>		ADDRESS <u>Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JOHN V. S.

OCT 11 1955

W. A. S. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

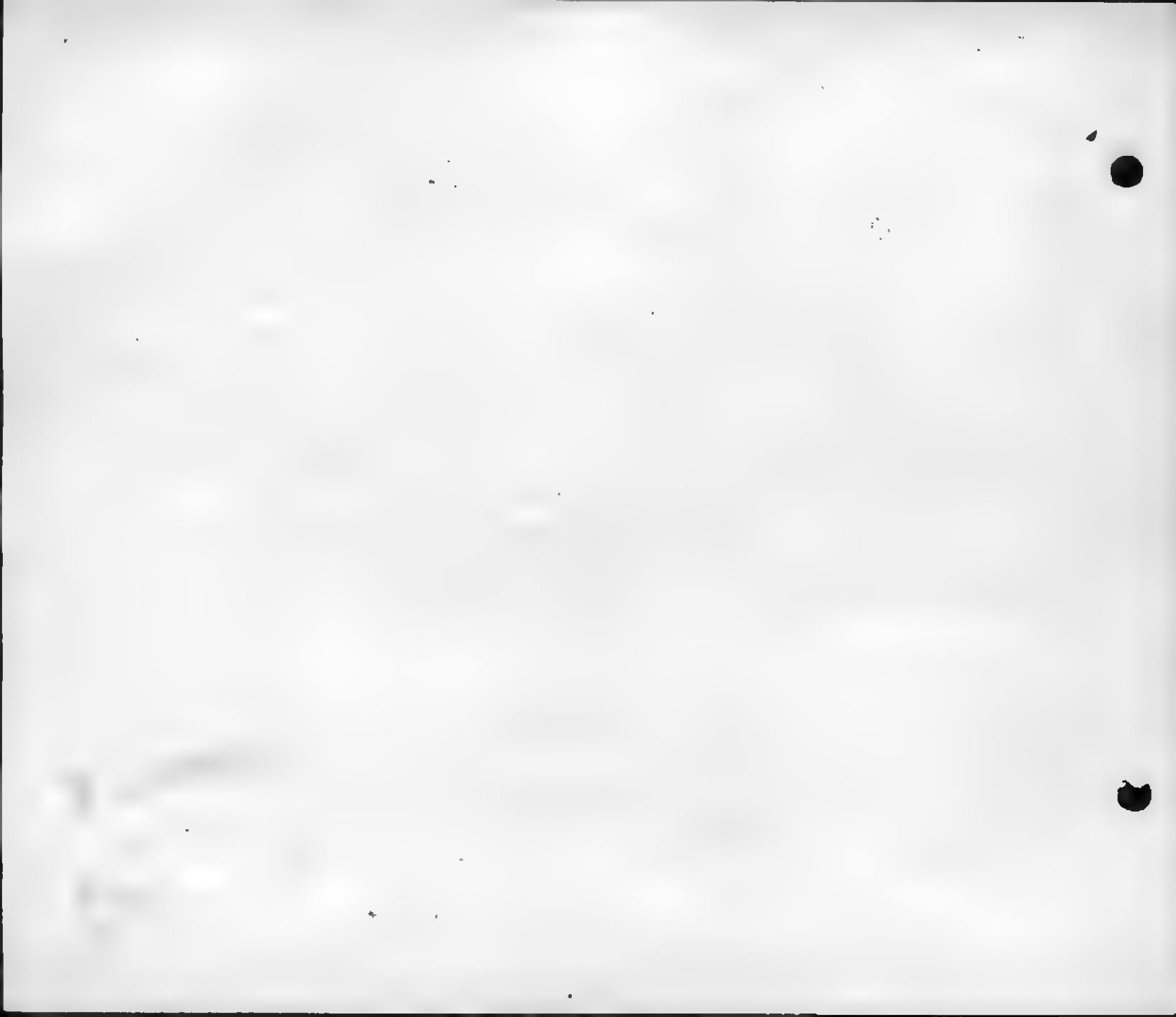
9741

CERTIFICATE OF DEATH

Reg. Dist. No. 131

09767

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Carroll</u>
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>11 TOWN Frederick</u>	LENGTH OF STAY (in this place) <u>1 day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Ridgeville</u>	<u>06X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 Frederick Mem. Hospital</u>		STREET ADDRESS (If rural give location) <u>Rural --Mt. Airy</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Ernest</u>	(Middle)	(Last) <u>Smith</u>	<u>Oct. 4, 1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>widowed</u>	8. DATE OF BIRTH: <u>12-25-1869</u>
9. AGE last birthday: <u>85</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Charles Smith</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Ann Becraft</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE: <u>490X Labor Pneumonia, left lower lobe</u>			
ANTECEDENT CAUSE (S): <u>4-5 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cirrhosis of the liver</u>			
19A. DATE OF OPERATION: <u>1</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/3</u> , 19 <u>55</u> , to <u>10/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/4</u> , 19 <u>55</u> , and that death occurred at <u>10¹⁵</u> AM, from the causes and on the date stated above.			
SIGNATURE <u>Henry V. Chase</u>		DATE SIGNED <u>10/4/55</u>	
ADDRESS <u>4 E. Church St</u>		M.D. <u>4 E. Church St</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-6-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		LOCATION (City, town, & county) (State) <u>Mt. Airy, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5 Oct 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Hack</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz</u>		ADDRESS <u>Winfield, Maryland</u>	



9763

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Frederick-Rural RD#5</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Frederick-Rural RD#5</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick County Chronic Hospital</u>				STREET ADDRESS (If rural give location) <u>Montevue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOSEPH WALTER SMITH</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>October 20, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Unknown</u>	8. DATE OF BIRTH: <u>12 Feb 1877</u>	9. AGE (last birthday) yrs. <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>561.5</u>							
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Intestinal Obstruction</u>						<u>5 days</u>	
(B) <u>Strangulated hernia (inguinal)</u>						<u>5 days</u>	
(C) <u>Atherosclerotic Cardio-vascular disease</u>						<u>18 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prostatic hypertrophy with urinary retention</u>						<u>2 weeks</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 13, 1955</u> , to <u>Oct. 20, 1955</u> , that I last saw the deceased alive on <u>Oct. 19, 1955</u> , and that death occurred at <u>4:40 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Bernard E. Kenna Jr. M.D.</u>		ADDRESS <u>M. D. Frederick, Maryland</u>		DATE SIGNED <u>20 Oct 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>20 Oct 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>20 Oct 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Hark</u>		24. FUNERAL DIRECTOR <u>M. P. Etchison & Son, Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9742

CERTIFICATE OF DEATH

Reg. Dist. No. 140...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<i>X</i> <i>Woodsboro</i>		<i>64 yrs.</i>		<i>Woodsboro</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>00</i>				<i>1</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>MRS MINNIE FLORENCE SMITH</i>				OF DEATH: <i>Oct 15 1955</i>			
5. SEX: <i>F</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed Jan. 12, 1872</i>		8. DATE OF BIRTH:	
				9. AGE last birthday: <i>83</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>John H. Baer</i>				14. MOTHER'S MAIDEN NAME: <i>Aunie S. Baursburg</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT & ADDRESS: <i>Dr. Allen R. Smith, Woodsboro, Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cerebral thrombosis</i>						<i>10 hours</i>	
ANTECEDENT CAUSE (B) <i>Arteriosclerotic - VD</i>						<i>10 years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>hypertensive - VD</i>						<i>2 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 1954</i> , to <i>14 Oct, 1955</i> , that I last saw the deceased alive on <i>14 Oct, 1955</i> , and that death occurred at <i>2 P M</i> , from the causes and on the date stated above.							
SIGNATURE <i>Wm S. Thomas</i>		M. D. <i>W. S. Thomas</i>		ADDRESS <i>Woodsboro Md</i>		DATE SIGNED <i>10.17.55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Oct. 18, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Hope</i>		LOCATION (City, town, or county) (State) <i>Woodsboro Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>10/17/55</i>		REGISTRAR'S SIGNATURE <i>R. E. Powell</i>		24. FUNERAL DIRECTOR <i>H. C. Barton</i>		ADDRESS <i>Walkersville, Md.</i>	

MARGIN RESERVED FOR BINDING

WILLIAM V. S.

OCT 10 1975

RECEIVED

9754

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sumner Road</u>	LENGTH OF STAY (In this place) <u>Church</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sumner Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Phenixville</u>		STREET ADDRESS (If rural give location) <u>near Phenixville</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>MICHAEL S. SPARKMAN</u>		<u>October 14 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>Aug. 21 1905</u>
9. AGE last birthday: (If under 1 year) (If under 24 hrs.)		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:	
yrs. <u>1</u> Months <u>10</u> Days <u>16</u> Hours <u>55</u> Min.			
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Samuel Sparkman</u>		14. MOTHER'S MAIDEN NAME: <u>Hazel Black</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT'S ADDRESS: <u>B. Sparkman, Phenixville, Md</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause <u>772.0 Auto intoxication</u>		<u>2 days</u>	
Antecedent causes (s) <u>Food not agreeing</u>		<u>2</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause stating the underlying cause last.		<u>1</u>	
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-12</u> , 19 <u>55</u> , to <u>10-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-13</u> , 19 <u>55</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. H. Legg</u>		DATE SIGNED <u>10-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Phenixville</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 14, 1955</u>		FUNERAL DIRECTOR <u>D. W. Hartzler</u>	
REGISTRAR'S SIGNATURE <u>J. H. Legg</u>		ADDRESS <u>Phenixville, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9743

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 11 TOWN Frederick		LENGTH OF STAY (in this place) Lifetime		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS M 5 North Bentz Street				STREET ADDRESS (If rural give location) 5 North Bentz Street			
3. NAME OF DECEASED:		(First) ADDIE		(Middle) ESTELLE		(Last) STUP	
5. SEX: Female		5. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: February 19, 1896	
				9. AGE last birthday: 59 yrs.		4. DATE OF DEATH: October 11, 1955	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife		10b. KIND OF BUSINESS OR INDUSTRY: Own home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Charles T. Fagan				14. MOTHER'S MAIDEN NAME: Addie M. Fraley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mr. Charles W. Stup - Frederick, Maryland			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
260X Immediate cause (a) Arterio-sclerotic coronary artery disease						30 years	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Diabetes Mellitus						8 years	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Work Not White At Work		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 2, 1953, to Oct 11, 1955, that I last saw the deceased alive on Oct 2, 1955, and that death occurred at 4:45 A.M., from the causes and on the date stated above.							
SIGNATURE Bernard C. Thomas Jr. M.D. Frederick Md.		(Degree or title)		ADDRESS		DATE SIGNED Oct. 12, 1955	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 10/14/1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 13 October 1955		REGISTRAR'S SIGNATURE Elizabeth G. Heck		24. FUNERAL DIRECTOR C. E. Clime & Son - Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the names of death clearly and legibly.



9765

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) Cullen		LENGTH OF STAY (in this place) 62 days		CITY (If outside corporate limits, write RURAL and give nearest town) Perryville 07X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) James (Middle) Willis (Last) Thompson				4. DATE (Month) (Day) (Year) OF DEATH: Oct. 19, 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Jan. 22, 1904	9. AGE last birthday: 51 yrs	10. UNDER 1 YEAR: Months	11. UNDER 24 HRS. Days	12. UNDER 24 HRS. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver				10B. KIND OF BUSINESS OR INDUSTRY: Truck driver.		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME: James N. Thompson				14. MOTHER'S MAIDEN NAME: Sarah Harris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-01-8521		17. INFORMANT & ADDRESS: Patient, Mr. James Willis Thompson	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cardio-respiratory failure.				INTERVAL BETWEEN ONSET AND DEATH few minutes			
ANTECEDENT CAUSE (B) Acute Pontocaine intoxication.				INTERVAL BETWEEN ONSET AND DEATH few minutes.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma of lung							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 18, 1955 , to Oct. 19, 19 55 that I last saw the deceased alive on Oct. 19, 19 55 and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>		M.D. Cullen, Maryland		DATE SIGNED October 21, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-22-55		NAME OF CEMETERY OR CREMATORY Asbury Cem.		LOCATION (City, town, or county) (State) Port Deposit, Md.	
DATE REC'D BY LOCAL REGISTRAR 10/21/55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[illegible]

9765

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Frederick</u>
(If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	(If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>mt. Pleasant</u>	<u>1 wk.</u>	TOWN <u>Rural, Le Gore</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
70		1	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH: <u>Oct 1 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec 15 1912</u>
9. AGE last birthday: <u>82</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Henry Toms</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO.: <u>216-22-1647</u>	
17. INFORMANT & ADDRESS: <u>Mr. Elwood Toms, Le Gore, md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Cardio-vascular disease</u>		20 YEARS	
ANTECEDENT CAUSE (S) (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Jan 1, 1954</u> , to <u>Oct 1, 1955</u> , that I last saw the deceased alive on <u>Sept. 30, 1955</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Bernard D. Fleming</u>		DATE SIGNED <u>Oct 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 4, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>mt. Hope Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodsboro, Fred Co., md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>30 Oct 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>Y. C. Barton, Walkersville, md.</u>	
REGISTRAR'S SIGNATURE <u>Elizabeth S. Hark</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

09774

9714

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
TOWN <u>Frederick</u>		TOWN <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick County Chronic Hospital</u>		STREET ADDRESS (If rural, give location) <u>277 Montevue in 4th St</u>	
3. NAME OF DECEASED (Type or Print) <u>Alexander</u> (First) (Middle) (Last) <u>Byler</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 25 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb 14 1928</u>
9. AGE last birthday <u>27</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Byler</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Montevue Records</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Chronic Granulomatous</u>				<u>5 yr.</u>	
Antecedent cause(s) (b) <u>After degenerative lungs (congestive)</u>				<u>Life</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 24</u> , 19 <u>55</u> , to <u>Oct 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 24</u> , 19 <u>55</u> , and that death occurred at <u>10:40 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>H. H. Kew</u>		M. D. <u>Frederick, Maryland</u>		DATE SIGNED <u>25 Oct 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE <u>26 Oct 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	
LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>		ADDRESS <u></u>	
DATE REC'D BY LOCAL REG. <u>25 Oct 1955</u>		REGISTRAR'S SIGNATURE <u>Eliza L. H. H. H.</u>			

7-11-00

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

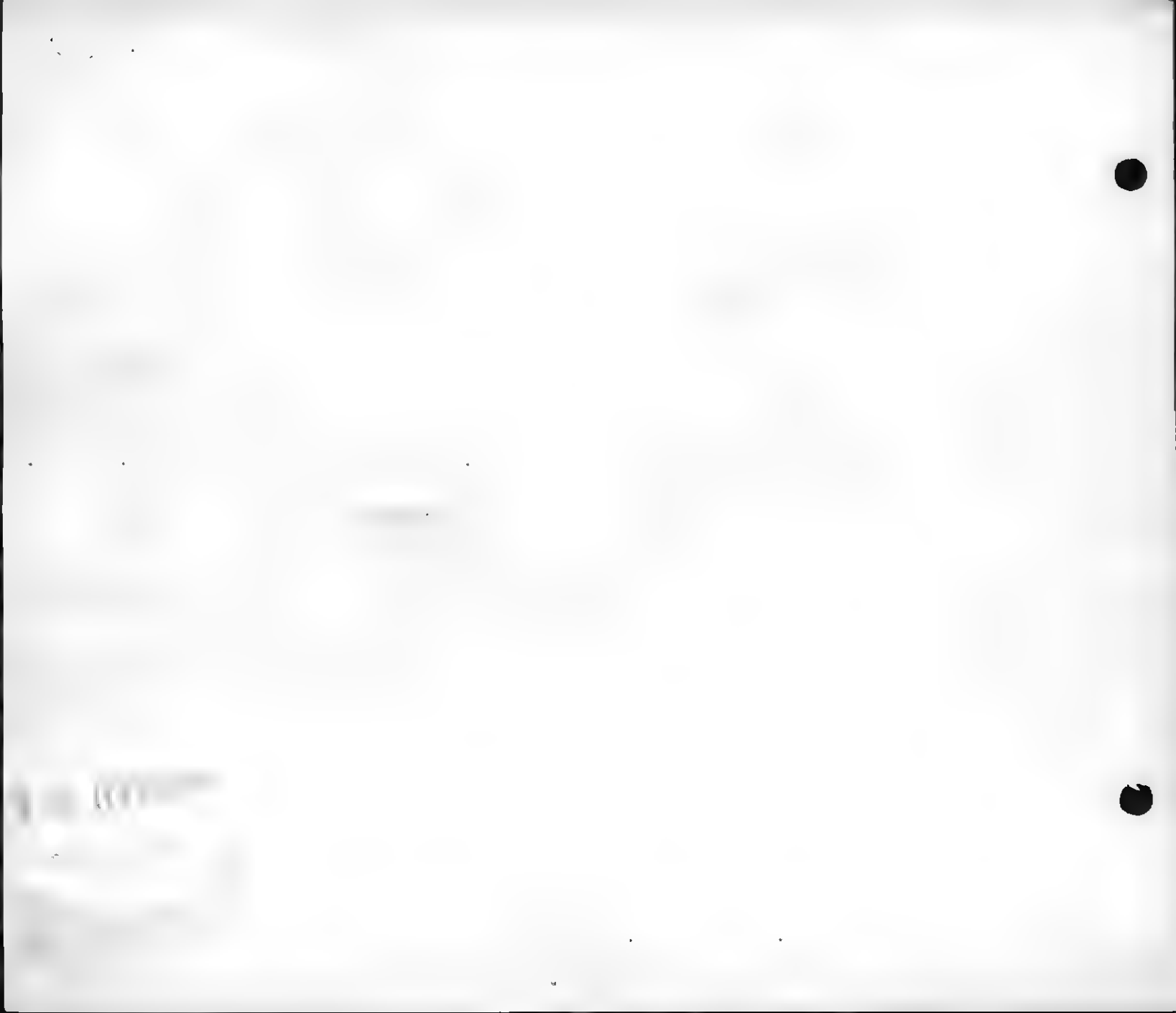
09775

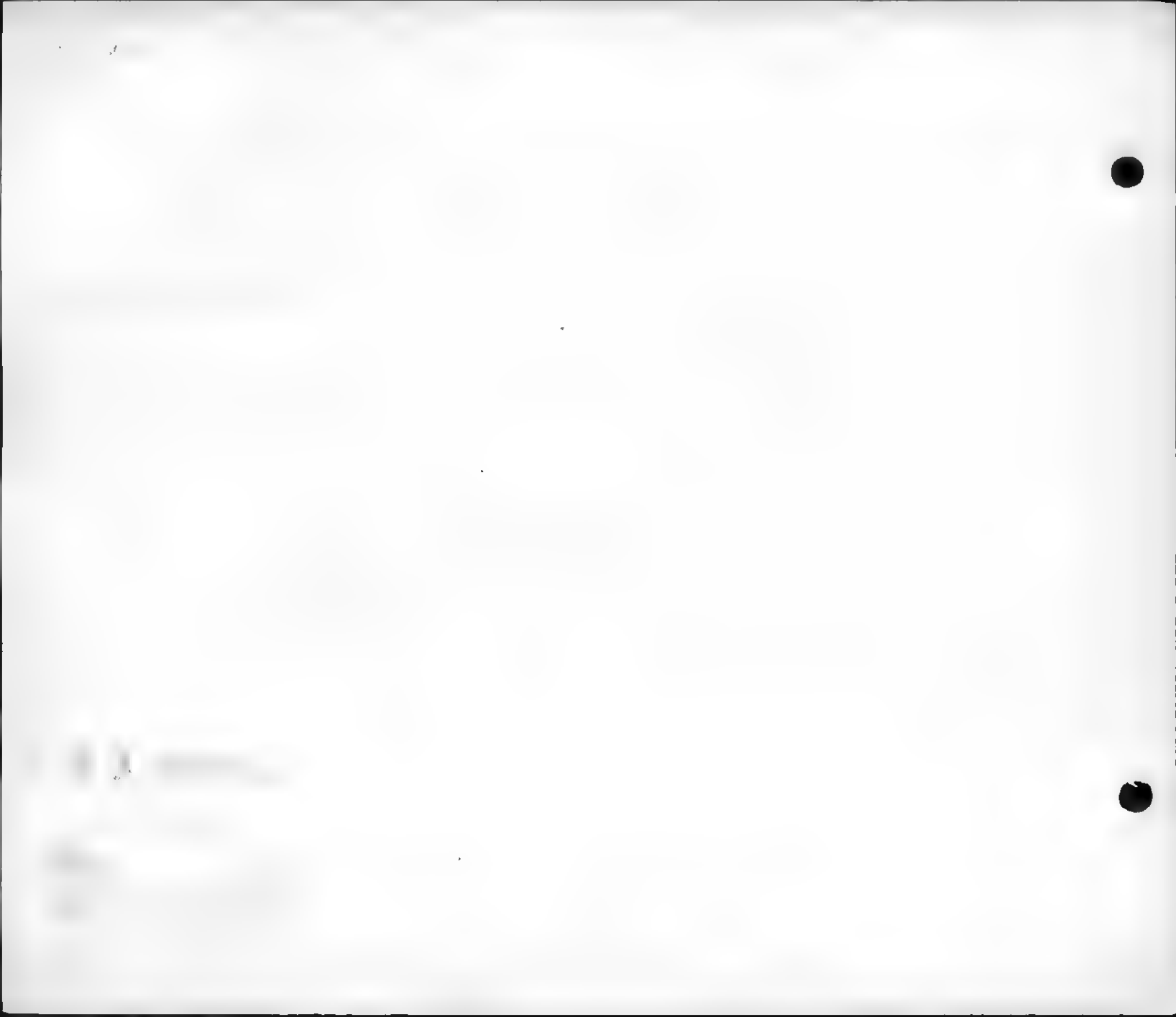
9767

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Middletown-Rural-R.D.#1		LENGTH OF STAY (In this place) 5 Years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Middletown-Rural-R.D.#1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 08				STREET ADDRESS (If rural give location) 7			
3. NAME OF DECEASED: (First) (Middle) (Last) DAISY VIOLET VALENTINE				4. DATE (Month) (Day) (Year) OF DEATH: October 5, 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH: October 14, 1879	9. AGE last birthday: 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY: Home		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Joseph H. Black				14. MOTHER'S MAIDEN NAME: Matilda C. Norris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Mrs. Ruhland C. Boyer, Middletown, R.D.#1, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) Broucho pneumonia				3 days	
ANTECEDENT CAUSE (B)		(B) Pyelonephritis				2 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertensive Cardiovascular Disease						10 years	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec., 1953, to Oct. 5, 1955, that I last saw the deceased alive on Oct. 5, 1955, and that death occurred at 10:20 A.M. from the causes and on the date stated above.							
SIGNATURE: J. R. Schaeffer		M.D. Frederick, Maryland		DATE SIGNED: 10/6/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF: Oct. 9, 1955		NAME OF CEMETERY OR CREMATORY: Mt. Tabor Cemetery		LOCATION (City, town, or county) (State) Frederick County, Maryland	
DATE REC'D BY LOCAL REGISTRAR: Oct. 1955		REGISTRAR'S SIGNATURE: Elizabeth G. Heck		24. FUNERAL DIRECTOR ADDRESS: M. R. Etchison & Son, Frederick, Maryland			





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09777

9759

CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH: COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>New Market</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>New Market</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS —		STREET ADDRESS (If rural, give location) —	
3. NAME OF DECEASED (Type or Print) (First) <u>Annie</u> (Middle) <u>ELiza</u> (Last) <u>Ways</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 24 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>UNKNOWN ABOUT 80 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UPTON CRAMPTON</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET MASON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY No. —	
17. INFORMANT AND ADDRESS <u>LAVINA HOLLAND NEW MARKET MD</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>
Immediate cause (a) <u>Generalized Arteriosclerosis</u>		
Antecedent cause(s) (b) <u>—</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1952, to October, 1955, that I last saw the deceased alive on October 23 1955, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W.B. Culwell M.D. Mt. Airy Md. October 24, 1955

23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE <u>OCT 29-55</u>	NAME OF CEMETERY OR CREMATORY <u>SIMPSONS CHAPEL</u>	LOCATION (City, town, or county) (State) <u>NEW MARKET MD</u>
DATE REC'D BY LOCAL REG. <u>OCT 26-55</u>	REGISTRAR'S SIGNATURE <u>Lucian H. Fahren</u>	24. FUNERAL DIRECTOR <u>W E Fahren</u>	ADDRESS <u>New Market Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

09778

9745

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Fred.	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 152 W. All Saints St.		STREET ADDRESS (If rural, give location) 152 W. All Saints St.	
3. NAME OF DECEASED (First) Joseph (Middle) Williams (Last)		4. DATE OF DEATH (Month) Oct. (Day) 28 (Year) 19 55	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, SINGLE (Specify)	8. DATE OF BIRTH May 5, 1888
9. AGE last birthday 67 yrs.		10. BIRTHPLACE (State or foreign country) Virginia	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Stone Quarry		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-1574	
17. INFORMANT AND ADDRESS Anna M. Ball 129 W. All Saints St.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause(a) *Cerebral hemorrhage*

INTERVAL BETWEEN ONSET AND DEATH

4 hrs.?

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <i>Home</i>		(CITY OR TOWN) <i>Frederick</i>	(COUNTY) <i>Frederick</i>	(STATE) <i>Md.</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
Burial	Oct. 30-55	Fairview	Frederick	Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
29 Oct. 1955	<i>Elizabeth S. Heck</i>	Charles E. Hicks III Fred. Md.		

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. ST.

NOV 1 1955

RECEIVED

9770

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY OR (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<i>X</i> TOWN <i>Rural</i>	<i>Life long</i>	TOWN <i>Rural - Frederick</i>	<i>X</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>EMMA</i>	(Middle) <i>ZIMMERMAN</i>	(Month) <i>Oct</i>	(Day) <i>14</i> (Year) <i>1955</i>
(Type or Print)			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>Feb 12, 1867</i>
		9. AGE last birthday: <i>88</i> yrs.	IF UNDER 1 YEAR: <i>8</i> Months <i>2</i> Days <i>0</i> Hours <i>0</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Frederick County Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>George W. Harris</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Ellen Staley</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>W. L. Smith Son in law Frederick Md</i>		18. MEDICAL CERTIFICATION	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <i>422.1</i>		<i>1 WEEK</i>
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(A) <i>BRONCHIAL PNEUMONIA</i> DUE TO (B) <i>CEREBRAL THROMBOSIS</i> DUE TO (C) <i>ARTERIOSCLEROTIC CVD</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<i>2 WEEKS</i>
		<i>20 YEARS</i>

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *11 Oct*, 1955, to *14 Oct*, 1955, that I last saw the deceased alive on *13 Oct*, 1955, and that death occurred at *6:20 AM*, from the causes and on the date stated above.

SIGNATURE <i>James E. Stoner Jr.</i>	M. D. <i>Wheatville, Md</i>	DATE SIGNED <i>14 October 1955</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <i>BURIAL</i>	DATE THEREOF: <i>Oct 16, 1955</i>	NAME OF CEMETERY OR CREMATORY: <i>Zion Reformed Church Cemetery</i>
DATE REC'D BY LOCAL REGISTRAR: <i>14 Oct. 1955</i>	REGISTRAR'S SIGNATURE: <i>Elizabeth S. Heck</i>	24. FUNERAL DIRECTOR: <i>BE Bailey</i>
		ADDRESS: <i>Frederick, Md.</i>

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BUREAU V. S.

OCT 18 1957

RECEIVED